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Living with Self-Criticism

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Portfolio submitted in fulfilment of the requirements for the
Professional Doctorate in Counselling Psychology (DPsych)

City University London
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Introduction to the Portfolio

This portfolio represents my journey towards becoming a Counselling Psychologist. It includes three parts, corresponding to different aspects of training. It commences with an empirical research project that explores the lived experience of the critical inner voice for women diagnosed with eating disorders. It then goes on to a client study that summarises my clinical work with a male client presenting with psychosexual difficulties. Lastly, with the hope of disseminating the findings from my research, the portfolio ends with a publishable paper that will be submitted to the journal *Eating Disorders*. The experience of living with self-criticism pervades this portfolio – research participants and my client report high levels of self-criticism which manifests in different ways but is rooted in similar cognitive and emotional processes.

Over the course of my work in the field of mental health, I have developed a particular interest in difficulties which encompass psychological and physical components. I have been fortunate enough to obtain training placements in services that deal with eating disorders and psychosexual problems and I have been able to work with clients presenting with a wide variety of difficulties that exemplify how emotional, cognitive, behavioural and physical symptoms can interact to perpetuate mental health problems. This portfolio encompasses a female perspective on eating disorders and a male perspective on sexual dysfunction. Eating disorders and psychosexual problems are often linked to experiences of self-criticism, shame and low self-esteem. These constructs are evident in all accounts and play a key role in maintaining the disorders.

Eating disorders are mostly prevalent in women whereas psychosexual problems are more common among men. I recall reflecting on this difference with my supervisor and noting how it partly relates to the ways in which men and women typically view themselves. Women have historically been encouraged to evaluate their self-worth and attractiveness with reference to their physical appearance whereas men have typically been influenced to focus more on concepts of performance and power when assessing themselves. I believe that these societal norms underpin the ways in which men and women typically criticise themselves and thus influence the prevalence of eating disorders and psychosexual problems. Self-criticism is often rooted in beliefs of defectiveness in relation to a perceived ideal, causing dysfunctional thoughts and behaviours in its pursuit. Although both types of problems are highly complex and diverse in their aetiology and presentation, they are somewhat linked to the harmful effects that gender norms have on individuals and the conditions of worth they may impose on themselves.

I first came across the “critical inner voice” when working in a specialist inpatient eating disorders service for young people. I was particularly struck by the patients’ high levels of self-criticism and how they often framed this experience as a voice or personified entity. This process was particularly prevalent after meals, and post-meal reflections often included patients experiencing negative self-talk or an inner voice accusing them of being greedy, disgusting and weak. These observations prompted me to decide to investigate this phenomenon from a research point of view.

In terms of therapeutic approaches, this portfolio explores a variety of perspectives but is primarily focused on Cognitive Behavioural Therapy (CBT). Participants’ experiences and the client study include considerations on this approach and one feature that transpires from both components is the helpfulness of concepts such as self-acceptance and self-compassion that are derived from “third wave” CBT approaches. These approaches are particularly relevant where presenting problems are related to self-criticism, shame and low self-esteem. It is also highlighted multiple times that the therapeutic relationship, as well as focus on interpersonal dynamics, are important in understanding and treating eating disorders and psychosexual difficulties.

The academic, research and clinical components of the Counselling Psychology doctorate, culminating in the production of this portfolio, have inspired me to continue learning about psychosexual problems and eating disorders, as well as developing my general practice. Furthermore, I have discovered an interest in third wave CBT approaches, as well as wishing to expand my knowledge of psychodynamic practice.

Section A: Doctoral Research

The aim of the research study is to explore in depth the lived experience of the “critical inner voice” for women presenting with eating disorders. The study employs the use of semi-structured interviews to gather data which is then analysed using Interpretative Phenomenological Analysis (IPA). This approach seeks to understand the subjective experience of individuals and how they make sense of that experience. Data analysis yields four groups of themes which represent my understanding and interpretation of participants’ lived experience. These themes are discussed with regard to existing literature and psychological theories, as well as therapeutic approaches. The implications and contributions for the field of Counselling Psychology are also identified and explored.

Section B: Client Study

The client study aims to demonstrate clinical skills, theoretical understanding and reflection upon the therapeutic process. This section explores my work with a male client presenting with excessive sexual drive characterized by increased use of pornography and erectile dysfunction. I describe the approach I used with the client, outline the key stages of therapy and evaluate our work. The case illustrates a cognitive behavioural approach to working with psychosexual problems. It exemplifies a relatively new type of presenting problem which has become increasingly widespread in recent years. Since research and clinical guidance on this type of difficulty are limited, I think it is valuable to illustrate a practical case example. Furthermore, I believe it is an effective piece of therapy which demonstrates my ability to flexibly and creatively apply my therapeutic skills.

Section C: Publishable Paper

This section consists of an abridged version of the doctoral research to be published in the peer-reviewed journal *Eating Disorders*. The formatting of the piece is in adherence with the journal guidelines. I chose this journal because it focuses on the prevention and treatment of eating disorders and it figures widely in the literature review section of the original research. The publication of this article would allow its dissemination to practitioners from a diverse range of disciplines, including counselling psychologists, who work with individuals affected by eating disorders.

SECTION A: DOCTORAL RESEARCH

Eating Disorders and Living with the "Critical Voice"

Abstract

Eating disorders are challenging to treat and have increased in prevalence in recent years. Existing research on the critical inner voice shows that individuals presenting with any eating disorder hear critical inner voices significantly more often than the general population. A qualitative exploration of this phenomenon aims to enhance the understanding of the critical inner voice and provide clinical recommendations.

Semi-structured interviews are conducted with nine women that are diagnosed with an eating disorder and report experiencing a critical inner voice. The transcripts are analysed using interpretative phenomenological analysis (IPA).

During the analysis stage four groups of themes are developed: "A Lifetime with the Voice" outlines how the voice may have come into existence and developed over time; "The Voice in Action" describes the central role the voice plays in eating disorders and all aspects of life; "Living with the Voice" highlights salient characteristics of the voice from cognitive, relational, emotive and social perspectives; "Coping with the Voice" describes personal experiences of managing the critical inner voice and addressing it in a therapeutic context.

The findings of the study emphasise the central role that the critical inner voice plays for individuals suffering from eating disorders. Participants' experiences highlight the limitations of CBT in addressing the critical inner voice, calling for a stronger focus on its emotive and relational aspects. Results suggest that elements of third wave CBT approaches as well as psychodynamic and humanistic models may be helpful in addressing the critical inner voice and eating disorders.

Chapter 1: Introduction and Literature Review

1.1. Introduction

This study aims to investigate how women affected by eating disorders experience the phenomenon of the critical inner voice. The principal focus of this chapter is to explore existing literature which is relevant to the research topic. I will begin by outlining the diagnostic criteria for all eating disorders and exploring their key features, incidence, core psychopathology and aetiology. Following this, I will review existing research relevant to the critical inner voice in eating disorders, with a particular focus on inner speech as its underlying cognitive process. Lastly, I will provide an overview of the treatments available for eating disorders – this will include therapeutic approaches recommended by the NICE guideline (2017) as well as approaches that are particularly relevant to participants' accounts of the critical inner voice. I will also describe how the critical inner voice may be conceptualised and addressed by each therapeutic approach. The chapter will end with a brief summary of the literature review and the rationale for the research, as well as the statement of the research aim and intended contribution to Counselling Psychology.

1.2. Eating Disorders

The fifth edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-5, American Psychiatric Association, 2013) includes a revised "Feeding and Eating Disorder" section which outlines three eating disorders: anorexia nervosa, bulimia nervosa and binge eating disorder. It also includes two residual diagnostic categories of specified and unspecified feeding and eating disorders. Several changes were made when reviewing the fourth edition of the DSM (DSM-4, American Psychiatric Association, 2000), with the aim of broadening the scope of eating disorders and therefore facilitating diagnosis and treatment. These changes will be described in the following sections.

Using figures for UK hospital admissions from 2012 to 2013, the eating disorders charity B-eat estimated that there were over 725,000 people with an eating disorder in the UK, approximately 90% of whom were female (B-eat, 2017). These figures also show that there has been an increase in admissions for eating disorders of 7% each year since 2005 (B-eat, 2017). About 15% of people with an eating disorder have anorexia nervosa, which is also more common in younger people. Most people with an eating disorder meet diagnostic criteria for bulimia nervosa, binge

eating disorder, or other specified feeding and eating disorders (NICE, 2017). Recent research shows that up to 6.4% of adults display signs of an eating disorders (B-eat, 2017). There is an even higher incidence of undiagnosed disordered eating in adolescent populations, as high as 10% of the general population (Smink et al., 2014). Recent studies also show that eating disorders have become more prevalent in non-western populations (Tong et al., 2014) and among ethnic minorities (Smink et al., 2014).

Eating disorders can develop at any age but the risk is highest for young people between the ages of 13 and 17 (NICE, 2017). Diagnostic criteria and screening tools are helpful in identifying eating disorders, however it is recommended that other factors are also considered. These include an unusually low or high BMI (Body Mass Index), dieting or changes in eating behaviour, social withdrawal, menstrual or other endocrine disturbances, abdominal pain or atypical dental wear (NICE, 2017). Eating disorders are also often associated with poor quality of life, social isolation and a substantial impact on family members and carers (NICE, 2017).

According to Fairburn (2008), eating disorders have a shared core psychopathology whereby most individuals display the over-valuation of shape and weight and their control. They judge their self-worth largely, or even exclusively, in terms of their shape and weight and their ability to control them (Fairburn, 2008). This core symptomatology results in sustained and extreme attempts to limit food intake in all eating disorders except binge eating disorder. Whether these attempts are successful or not will, in part, determine diagnosis, as will behaviours such as excessive exercising, binge eating and/or purging (Fairburn, 2008). This transdiagnostic view of eating disorders is based on evidence regarding the longitudinal development and clinical features of eating disorders. Studies show that many individuals migrate between diagnoses over the course of their illness (Fairburn, 2008). Eating disorders have a tendency to persist but evolve in form, however they rarely evolve into other psychiatric disorders, suggesting that transdiagnostic mechanisms play a major role in maintaining eating disorder psychopathology. In many cases patients begin presenting with symptoms of anorexia nervosa and later develop binge eating and progress to bulimia nervosa or a mixed form of eating disorder (Fairburn, 2008). Furthermore, from a cross-sectional perspective, there is a significant overlap between anorexia nervosa and bulimia nervosa, whereby some individuals meet the diagnostic criteria for both disorders (Fairburn, 2008). Recent studies have provided further support for the view that eating disorders share a core psychopathology (Trottier et al., 2015, Forrest et al., 2018). If this is the case, it could also be argued that treatments that are capable of addressing these mechanisms should be effective with all eating disorders, as will be discussed later in this chapter.

Although eating disorders primarily manifest through preoccupation with diet, weight and shape, these are often a symptom of underlying difficulties (Gowers & Shore, 2001). Eating

disordered behaviours are often a way of coping with emotions or events that feel difficult or overwhelming. Initially they may develop as a means for individuals to feel in control of their life but ultimately they cause damaged physical and psychological health as well as a reduced sense of control (Treasure & Schmidt, 2003). Eating disorders are complex conditions that can arise as a result of biological, emotional, social, interpersonal and psychological factors (Birmingham & Beumont, 2004; Polivy & Herman, 2002). Environmental stressors, such as relationship problems (Schmidt et al., 1997) or traumatic life events can trigger the onset of an eating disorder (Smyth et al., 2008). A genetic predisposition, family influences and parental modelling have also been shown to play a role (Castro-Fornieles et al., 2007; Thompson, 1996). Personality features such as the need for control (Polivy & Herman, 2002) and perfectionism (Castro-Fornieles et al., 2007) have also been associated with the development of eating disorders.

I will now outline the diagnostic criteria and briefly describe each eating disorder. I will contextualise these by reviewing some qualitative research about the individual experience of each disorder, in line with the qualitative perspective of this study. The similarities across the qualitative research presented further support the notion that eating disorders share a core psychopathology.

Diagnostic criteria for eating disorders can be helpful tools but, in my opinion, must not overshadow the needs and characteristics of each individual. Counselling Psychology has a critical relationship with the concept of diagnosis, acknowledging its usefulness but keeping in mind its limitations. A number of practical functions have been claimed for diagnosis, including communication, legitimizing distress and facilitating treatment (Coles & SPIG, 2010). Questions have also been raised about the reliability and validity of diagnosis (Kirk & Kutchins, 1994) and its potential negative effects (Bentall, 2007). The discipline of Counselling Psychology has invited further critique and reflection with the aim of proposing alternatives to psychiatric diagnosis (Coles & SPIG, 2010). A review by the East Midlands Psychosis and Complex Mental Health Special Interest Group highlighted several potential problems with psychiatric diagnosis, including the prioritisation of biological explanations at the expense of contextual understandings, an imposition of a western cultural worldview, and the maintenance of power dynamics in communication between mental health staff and service users (Coles & SPIG, 2010). Alternatives to diagnosis were suggested, such as focusing on specific experiences and difficulties within a person's life, thus creating the potential for a shared language between staff and service users. It was also suggested that context-specific measures and goals could be used in assessment and treatment, rather than fixed diagnostic criteria (Coles & SPIG, 2010).

Anorexia Nervosa

According to the Diagnostic and Statistical Manual for Mental Disorders (DSM-5, American Psychiatric Association, 2013), in order for anorexia nervosa to be diagnosed, the following criteria must be met:

1. Restriction of energy intake relative to requirements leading to a significantly low body weight;
2. Intense fear of gaining weight or becoming fat or persistent behaviour that interferes with weight gain even though at a significantly low weight;
3. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation or persistent lack of recognition of the seriousness of the current low body weight.

Two types of anorexia nervosa are further identified: the restricting type, where weight loss is accomplished primarily through dieting, fasting or excessive exercise, and the binge-eating/purging type, where the individual engages in recurrent episodes of binge-eating or purging behaviour.

The DSM-4 was revised to broaden the scope of anorexia nervosa diagnosis by removing criteria relating Body Mass Index (BMI) and amenorrhea in females. It is widely thought that these criteria were not relevant to all individuals and were preventing some from accessing treatment before their condition became severe, hindering the possibility of early intervention.

Mortality rates for anorexia are the highest of all psychiatric illnesses at 10-15% (Crisp, 2006). It is predominantly a female disorder and only an estimated 10% of those diagnosed are male (Lucas et al., 1991). It is also less prevalent in non-westernized countries and is more common among those of middle to high socio-economic status (Cooper, 1987).

Qualitative research about the experience of anorexia has found that the underlying psychological factors are felt to be more important by sufferers than the physical aspects of the illness (Williams et al., 1993). Although each individual experiences the disorder in a unique way, some commonalities emerge. Self-disgust, self-hatred, inadequacy and shame appear to be key features of the experience of anorexia nervosa. At the same time, elements of the disorder seem to offer a solution to shame and solitude, creating a vicious cycle (Rance et al., 2017). Anorexia nervosa has also been described by some as having the quality of a separate entity within themselves – it can nearly feel like an internal battle between two parts of the self (Ross & Green, 2011). Anorexia nervosa is understood by some as a response to a sense of loss of control in their lives and often relates to disturbances in self-image and problems with interpersonal relationships (Button & Warren, 2001).

Bulimia Nervosa

The diagnostic criteria for bulimia nervosa according to the Diagnostic and Statistical Manual for Mental Disorders (DSM-5, American Psychiatric Association, 2013) are:

1. Recurrent episodes of binge eating, defined as eating, in a discrete period of time, an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances with a sense of lack of control over eating;
2. Recurrent inappropriate compensatory behaviours in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting, or excessive exercise;
3. The binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for three months;
4. Self-evaluation is unduly influenced by body shape and weight;
5. The disturbance does not occur exclusively during episodes of anorexia nervosa.

Once again, the diagnostic criteria of DSM-4 were revised to allow more flexibility in diagnosis and facilitate early intervention. The frequency of bingeing and compensatory behaviours required for diagnosis was changed from twice a week to once a week.

Bulimia nervosa may cause serious somatic complications contributing to an elevated mortality rate. It is also associated with mood swings and problematic social interactions (Nielsen, 2001). Unlike anorexia nervosa, which seems to affect specific ethnic groups more than others, bulimia equally affects people of all age groups, ethnic backgrounds and social classes (Broussard, 2005; Southard, 2009).

It has been found that sufferers of bulimia nervosa tend to conceal their symptoms for fear of stigmatization. Behaviours such as bingeing and purging often cause intense feelings of shame and their concealment is a way to preserve dignity. This may lead to individuals feeling like they have a “double life” (Pettersen et al., 2008). It may also cause sufferers to fear being found out and therefore fosters isolation (Broussard, 2005). Analysing discourse in bulimia sufferers identified that they often speak of their illness as an external entity which acts on them and debilitates them – they feel like victims (Brooks et al., 1997). They describe a mental and psychological battle within themselves which is similar to a feeling of being “possessed” (Broussard, 2005).

Binge-Eating Disorder

Binge-eating disorder is defined by the Diagnostic and Statistical Manual for Mental Disorders (DSM-5, American Psychiatric Association, 2013) as comprising of the following symptoms:

1. Recurrent episodes of binge-eating, defined as eating, in a discrete period of time, an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances with a sense of lack of control over eating;
2. The binge-eating episodes are associated with three or more of the following: eating much more rapidly than normal, eating large amounts of food when not physically hungry, eating alone because of feeling embarrassed by how much one is eating; feeling disgusted with oneself, depressed, or very guilty afterwards;
3. Marked distress regarding binge eating is present;
4. The binge-eating occurs, on average, at least once a week for three months;
5. The binge-eating is not associated with the recurrent use of inappropriate compensatory behaviour as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

Binge-eating disorder was not previously specified in DSM-4, the presentation used to be diagnosed under the category of “Eating Disorders Not Otherwise Specified”. The decision to add the disorder was made following a considerable amount of research indicating that binge-eating disorder warrants a specific diagnosis that has validity and consistency (Swanson et al., 2011).

Binge-eating disorder is associated with high levels of obesity and psychological suffering (Mustelin, 2017). In some individuals it may lead to a choice to undergo bariatric surgery (Marek et al., 2014). Unlike other eating disorders, binge-eating disorder is equally prevalent in men and women (Grucza, 2007) and across ethnic groups (Smith et al., 1998).

Qualitative research shows that some key features of the experience of binge-eating disorder are secrecy, self-hate and low self-worth (Cranston, 2011). The disorder can be described as a “relentless battle”, often starting at a young age and progressing with time. Binge-eating behaviour may be experienced as an emptiness to be filled with food (Cranston, 2011). Feelings of not being good enough and poor body image are also common in those diagnosed with binge-eating disorder (Sandy, 2007). It is also common for individuals to have experienced trauma and to present with binge-eating episodes in combination with dissociation (Starkman, 2005).

Other Specified and Unspecified Feeding and Eating Disorders

The Diagnostic and Statistical Manual for Mental Disorders (DSM-5, American Psychiatric Association, 2013) includes two residual categories. “Other specified feeding or eating disorders” include presentations in which symptoms do not meet the full criteria for any of the other eating disorders but still cause clinically significant distress or impairment in functioning. Examples of presentations in this category include atypical anorexia nervosa, bulimia nervosa of low frequency, purging disorder. “Unspecified feeding or eating disorders” are diagnosed where the clinician chooses not to specify the reasons that the criteria are not met and includes presentations for which there is insufficient information to make a more specific diagnosis.

In the previous DSM-4 there used to be only one residual category of “Eating Disorders Not Otherwise Specified”. This included atypical presentations that would now fall under the above diagnoses which have been broadened or added (Vo et al., 2017). It would also include presentations within both the residual categories in DSM-5. The additional category of “unspecified feeding or eating disorders” allows clinicians to diagnose an eating disorder without highlighting any specific symptoms or features. This may allow access to treatment and maintain flexibility, for example, while further information is being gathered.

Eating disorders belonging to the residual categories are still associated with considerable clinical severity (Mustelin, 2016). Qualitative research on the lived experience of eating disorders as a whole further illustrates their salient common characteristics. One study highlights that each individual experiences their disorder differently and its manifestation can be highly personal and complex, with multiple layers of meaning (Mcparland, 2008). Participants often describe the onset of their eating disorder as occurring during childhood or adolescence. They also describe it as an intrusive presence, characterized by feelings of ambivalence (Mcparland, 2008).

I have described each eating disorder separately, however this research is based upon the premise that all eating disorders share a core psychopathology, as described earlier in the chapter. The qualitative studies presented above show that there are considerable similarities in the way that eating disorders are experienced by individuals, with self-criticism, self-hatred and the presence of an entity separate from themselves seemingly common features. I have therefore decided to investigate the experience of the critical inner voice across all eating disorders.

I will now move on to outlining existing literature that is directly relevant to the critical inner voice experienced by individuals with eating disorders.

1.3. The Critical Inner Voice

Before outlining existing research on the critical inner voice experienced by individuals with eating disorders, I feel it is important to explore the phenomenon of inner speech in the general population. I will begin by outlining the role of inner speech as a self-regulatory mechanism and how it may also play a part in psychopathology. I will then review existing research relating to the critical inner voice in eating disorders, which could be seen as an aspect of inner speech that has become particularly prominent in individuals suffering from eating disorders.

Inner Speech as a Self-Regulatory Mechanism

The inner voice we may all have in our minds, when we reflect or talk to ourselves, is most commonly referred to as “inner speech” in the research literature. Inner speech can be defined as the subjective experience of language in the absence of overt and audible articulation (Alderson-Day & Fernyhough, 2015) or the process of silently talking to oneself (Morin, 2009). Other terms used for this phenomenon include “verbal thinking”, “internal monologue” or “internal dialogue”. Inner speech is thought to play an important role in the self-regulation of cognition and behaviour in children and adults (Alderson-Day & Fernyhough, 2015). Researching inner speech empirically poses methodological challenges and has therefore not attracted substantial research focus until relatively recent years, in line with methodological advances. A large body of research is now present on inner speech relating to disparate fields such as developmental psychology, cognitive neuroscience, and psychopathology.

Despite this phenomenon figuring in psychological, scientific and philosophical discourse for centuries (Fernyhough, 2013), theories about inner speech have emerged fairly recently. Early theories of inner speech have focused on its cognitive functions. Watson (1913) saw inner speech as equivalent to thinking – as a part of language development there would be a gradual reduction of self-directed speech, which becomes more and more quiet and eventually becomes silent thought. By contrast, according to Vygotsky’s (1987) theory of cognitive development, inner speech is the outcome of a developmental process and is more complex than simply a by-product of the behavioural components of speaking. Vygotsky proposes that linguistically mediated social exchanges, such as interactions with caregivers, are gradually internalised and transformed into a conversation with the self. He saw evidence for his theory in the phenomenon of “private speech” observed in children, whereby they may talk to themselves as commentary to performing cognitive tasks. He saw private speech as a step towards internalisation of interpersonal dialogues that would have previously provided guidance. Further research upholds private speech and inner speech as key components of cognitive

development and also persisting into adulthood as valuable self-regulatory and motivational tools (Alderson-Day & Fernyhough, 2015; Winsler & Naglieri, 2003; Winsler et al., 2003). Inner speech has also been proposed to play an important role in metacognition, self-awareness and self-understanding (Morin, 2005). Larrain & Haye (2012) propose that inner speech has an even broader purpose and is not just one psychological process among others, but the way in which we structure psychological processes through language practices.

Inner speech is a psychological process with no overt behavioural manifestation, it has therefore been challenging to study empirically. In recent years, a number of direct and indirect methods have been employed to capture the phenomenon of inner speech. Questionnaires have been designed so that participants may report directly on the occurrence of their inner speech, its content and function. These include the Scale for Inner Speech (Siegrist, 1995), the Self-Verbalization Questionnaire (Duncan & Cheyne, 1999), the Self-Talk Use Questionnaire (Hardy et al., 2005), the Self-Talk Scale (Brinthaup et al., 2009) and the Varieties of Inner Speech Questionnaire (McCarthy-Jones & Fernyhough, 2011). Questionnaire subscales often show good reliability but correlations among subscales can be weak, potentially indicating limited validity or that subscales are measuring different aspects of the same complex construct (Morin et al., 2011). Some of these questionnaires have been employed to study the content and function of inner speech and how it may relate to psychopathology traits, as will be explored in the following section.

Another method which aims to capture inner speech more spontaneously, rather than over a period of time, is “experience sampling” (Csikszentmihalyi & Larson, 1987). This approach involves asking participants about the nature and content of their experience at the moment of a random alert. Experience sampling studies have sought to explore inner speech by capturing moments of spontaneous experience. An early study found that instances of “interior monologue” were reported in roughly three quarters of samples (Klinger & Cox, 1987). Hurlburt et al. (2013) perfected the methodology and found that individuals typically perceive themselves to be speaking in their own voice and in complete sentences but without vocalisation. They may address themselves or another and the utterances are experienced as being actively produced rather than passively heard (Hurlburt et al., 2013). It will be interesting to notice whether participants in this study experience the critical inner voice in a similar way.

In summary, inner speech is a phenomenon that we all experience from an early age, and it plays an important role in self-regulation of cognition and behaviour. Early theories compare inner speech to thinking, whereas others hold that it is a distinct cognitive process which relates to internalised interactions with others. It has been found to contribute to identity formation, self-awareness and motivation. It may even have a broader purpose, as a cognitive function which

aides us in structuring other psychological processes through language. The content, form and functions of inner speech have been studied using methods such as questionnaires and experience sampling. The critical inner voice may well be an aspect of inner speech that has become particularly prominent in individuals with eating disorders.

Inner Speech and Psychopathology

I will now outline some key research on inner speech and how it may relate to psychopathology traits, as I believe that it could provide useful material that can be related to the experience of the critical inner voice in eating disorders. This novel perspective on the critical inner voice may also illuminate further research opportunities.

Calvete et al. (2005) developed a questionnaire to measure Negative and Positive Self-Talk and explored the correlation between these and psychopathology traits in a normal population. The negative scale included items about anxious, depressive and angry self-talk while the positive scale included items on coping, minimisation of worry and positive orientation. As predicted, there was a significant correlation between the scales and trait measures of psychopathology. For example, trait depression was strongly predicted by depressive self-talk and trait anxiety was strongly predicted by anxious and depressive self-talk. Positive self-talk relating to minimizing worry was negatively associated with anxiety and anger, while positively oriented self-talk was linked to lower depression but higher levels of anger. Such results show that inner speech may be involved in the representation of every day mood states. It may also be that measures of self-talk and psychopathology traits are measuring different aspects of the same phenomenon, making causality difficult to determine. These findings mirror cognitive models of psychopathology, which hold that cognitive processes underlie mental health difficulties such as anxiety and depression (Beck, 2008; Buschmann et al., 2018). For example, depression is thought to be linked to negative cognitions or “negative automatic thoughts” (Clark et al., 1999). Inner speech and thoughts are both cognitive processes and as such are likely to play a role in the development maintenance and recurrence of depression (Williams et al., 1997) as well as other disorders.

The Self-Talk Scale (Brinthaup et al., 2009) evaluates individual differences in self-talk frequency and function. The scale consists of 16 items using the common stem “I talk to myself when...”. It has a structure consisting of one higher-order factor (overall self-talk) and four primary factors (self-critical, self-reinforcing, self-managing, and social-assessing self-talk). “Self-critical self-talk” is generally associated with negative evaluations (e.g., “I feel ashamed of something I’ve done”). “Self-reinforcing self-talk” focuses on positive evaluations (e.g., “I’m proud of something

I've done"). "Self-managing self-talk" relates to general self-regulation (e.g., "I'm giving myself instructions or directions about what I should do or say"). Finally, "social-assessing self-talk" pertains to people's social interactions (e.g. "I want to analyse something that someone recently said to me"). In their questionnaire validation work, Brinthaup et al. (2009) found negative associations between social-assessing and self-critical self-talk and self-esteem, as well as a positive relationship between self-reinforcing self-talk and self-esteem. Frequent self-talkers also scored higher than infrequent self-talkers on obsessive-compulsive tendencies. A similar study revealed that anxiety and impulsivity were positively associated with both self-critical and self-reinforcing self-talk (Ren et al., 2016). Once again, some of these functions of inner speech may bear a resemblance to the critical inner voice.

The Varieties of Inner Speech Questionnaire (McCarthy-Jones & Fernyhough, 2011) is an 18-item measure which focuses on the quality and structure of inner speech and consists of four underlying factors: "dialogic inner speech", or the tendency to engage in inner speech with a conversational quality, "condensed inner speech", which has an abbreviated or fragmentary form, "other people in inner speech", a representation of others' voices or something they would say, and "evaluative/motivational inner speech", which serves to judge or assess one's behaviour. Using data from several samples, it was found that inner speech with evaluative/motivational characteristics was the most common (82.5%), dialogic inner speech was nearly as prevalent (77.2%), while condensed inner speech (36.1%) and other people in inner speech (25.8%) were less prevalent (McCarthy-Jones & Fernyhough, 2011). Further research showed that evaluative inner speech and other people in inner speech were both positively associated with trait anxiety and depression, and evaluative inner speech was associated with low levels of self-esteem (Alderson-Day et al., 2014). It sounds like some of the varieties of inner speech in this study may bear a close resemblance to aspects of the critical inner voice, it will be interesting to notice whether this is the case based on participants' accounts. My research, although qualitative, may be able to complement some of these findings, providing the basis for further research on eating disorders and inner speech.

Several studies have also been carried out to investigate the experience of inner speech in atypical populations. Moritz et al. (2014) asked individuals with depression to report on the sensory phenomenology of their depressive thoughts. Auditory properties, such as experiencing an "inner critic" were reported by 31% of the sample. Anxiety and depression are generally known to be associated with ruminative thought processes (Harrington & Blakenship, 2002; Nolen-Hoeksema, 2000), which are predominantly verbal in nature (Nolen-Hoeksema, 2004). Worrying often takes a verbal form and it has been found that this can have a stronger impact on anxiety levels than worry in other modalities, such as visual imagery (Stokes & Hirsch, 2010).

The tendency for worry to be linked to verbal processes is consistent with research on generalised anxiety disorder (Behar et al., 2005). The critical inner voice is also a cognitive process which is verbal in nature and, as the above research suggests, there is a strong link between such processes and psychopathology.

The above research shows that some of the content of inner speech is related to psychopathology traits in a normal population. Different types of inner speech are also positively associated with trait anxiety and depression, whereas certain functions of inner speech have been shown to correlate with self-esteem and obsessive-compulsive tendencies. Furthermore, research shows that ruminative thought processes which are verbal in nature play an important role in anxiety and depression. Inner speech therefore appears to be highly relevant to psychopathology, indicating its similarity to internal experiences such as the critical inner voice.

The Critical Inner Voice and Eating Disorders

Having reviewed research on inner speech and psychopathology traits, I will now focus on the phenomenon of the critical inner voice in eating disorders. A functional definition of this phenomenon was provided by Nordenboos et al. (2013) as a voice which may judge, criticize or tell individuals how to behave. Research indicates that over 90% of eating disorder sufferers describe experiencing a critical inner voice (Noordenbos, 2014). Similar “inner voices” are also widely found in other non-psychotic disorders including obsessive-compulsive disorder, post-traumatic stress disorder and emotionally unstable personality disorder (Brewin & Patel, 2010; Gangdev, 2002; Hepworth et al., 2013).

Models of auditory hallucinations have at times been applied to the experience of the critical inner voice in order to understand how it interacts with pathology (Pugh, 2016), however it is clear from existing research that such voice is not psychotic in nature. The literature clearly refers to the critical inner voice as internally produced rather than externally generated and not a psychotic hallucination (Higbed & Fox, 2010), but rather a pseudo-hallucination or “inner voice” (Hare, 1973). It may be just an aspect of inner speech that has become more prominent in individuals diagnosed with eating disorders (Pugh, 2016).

According to Firestone (1986) hearing an inner voice is not a real sensory perception or an auditory hallucination but rather a system of thoughts experienced as an actual voice. A psychoanalytic explanation of the phenomenon of critical inner voices was developed by Freud (as cited in Firestone, 1986) who described a division of the ego into two parts, which come into conflict in individuals suffering from depression. This may also be applicable to eating disorder

sufferers to describe their struggle with their critical inner voice. A similar concept of the “inner critic” was introduced by Gendlin (1984) within person-centred theory. It refers to a system of critical and negative thoughts and attitudes towards the self that interferes with the individuals’ organismic experiencing process. Similar concepts are also described in other therapeutic approaches, for example “harsh superego” in psychoanalysis, “critical parent” in transactional analysis or “top dog” in Gestalt therapy.

One of the first accounts of the critical inner voice was in the book by Hilde Bruch (1978) in which one of her patients revealed that she experienced an “inner dictator” in her head who dominated her life. Other authors have referred to similar experiences such as having an “inner negativist” (Claude-Pierre, 1997) or an “inner saboteur” (Kortink, 2008). The concept of the “anorexic voice” has been evidenced in personal accounts written by individuals with anorexia nervosa, who have described an entity criticising them and compelling them to engage in eating disordered behaviours (Fathallah, 2006; Hendricks, 2003). Further qualitative research on eating disorders confirmed the presence of the critical inner voice. Individuals suffering from anorexia nervosa experienced a voice which seemed to be an important phenomenological aspect of their condition (Higbed & Fox, 2010). They often reported hearing a critical inner voice which instructed them to reduce their food intake and their weight (Noordenbos et al., 2014). Individuals with bulimia nervosa described similar experiences with inner voices that may order them to binge or purge (Broussard, 2005). The voices were critical and controlling, creating an experience similar to a “psychological battle” of conflicting thoughts within themselves (Nottelman & Thijssen, 2010).

There has been a limited amount of research focusing specifically on the phenomenon of the critical inner voice in eating disorders and most studies focus on anorexia nervosa and the “anorexic voice”. Therefore, for the purpose of reviewing the literature I will use the terms “anorexic voice”, “critical inner voice” or “voice” interchangeably. It is clear from existing literature, that this voice is not always critical but can also be source of support, motivation and companionship.

In anorexia the voice is described as primarily critical and as providing the individual with messages about the importance of engaging in anorexic behaviours as well as avoiding external pressure to eat more normally (Tierney & Fox, 2010; Williams & Reid, 2012). The anorexic voice comments on the individual’s eating, weight and shape and instructs them to engage in eating disordered behaviours (Pugh & Waller, 2017). The anorexic voice is usually experienced as an inner dialogue or second person commentary on shape, weight, eating and their implications for self-worth (Pugh & Waller, 2016; Pugh, 2016). It is important to note that such topics echo

the core psychopathology of all eating disorders (Fairburn, 2008) and are therefore likely to be featured in the critical inner voice for other eating disorders as well.

Wade (2003) researched the internal landscape of anorexia nervosa and found that it was dominated by the experience of inner voices. Six participants diagnosed with anorexia nervosa were interviewed and the data was analysed using a phenomenological method. Participants were asked about their most significant internal experiences in detail and it was found that they often heard persecutory, taunting, critical voices that would abuse them for eating, being fat and ugly. Participants often felt intense self-hatred and were led to aspire to be perfect in order to be loved. Over the course of recovery, participants became more able to evaluate these voices and began to develop alternative voices of resistance and resilience which were critical to recovery.

A study by Tierney and Fox (2010) particularly aimed to investigate individuals' encounters with and reflections on living with the "anorexic voice". They employed a qualitative method which involved asking participants to give an account of what it was like for them to live with this voice. Participants were given suggestions such as writing a description, a poem or a conversation. Twenty-two participants took part in the study and the data was analysed using a thematic approach to identify key concepts present in participants' contributions. The researchers outlined ten categories which described the experience of the anorexic voice. These were: feeling part of something, giving a steer to life, providing comfort and safety, constant presence, entrapped in an undesirable situation, attacking sense of self, demanding and harsh task master, powerful entity, dangerous state of being, breaking free. They further noted a pattern in the evolution of participants' experiences over time whereby the voice initially appeared to have positive characteristics and then evolved into a more negative experience. Participants described the voice entering their life at a time when they were vulnerable. It was a source of comfort and brought order to their lives, supporting them in decision making and providing companionship. Over time participants described the voice becoming stricter and more controlling, dictating what they should do and degrading them for failing to abide by its rules and exacting standards. It demanded an exclusive relationship and attempted to turn participants away from people by twisting their motives, it encouraged them to lie to family, friends and professionals in order to maintain the eating disordered behaviours. Eventually, participants reported feeling let down by their voice and acknowledging its destructive and dangerous nature. They began to challenge the voice and to distance themselves from it. Despite this a number of participants were concerned about losing its companionship and experienced a sense of loss.

A further qualitative study by the same authors drew a parallel between the experience of living with the anorexic voice and the experience of domestic violence. Similarly to an abuser, participants described an inner voice that dominates their thinking and behaviour and prevents them from progressing towards recovery (Tierney & Fox, 2011). A key theme from this study was the toxic relationship participants described with their inner voice. At the same time, it was clear that the inner voice was also a source of comfort and support. However, it quickly changed into a controlling force pushing them and their bodies into extreme eating disordered behaviour. The voice undermined their confidence with critical remarks and made them believe life without it was impossible. This study described living with the voice as a “prison-like” existence, dominated by rules and harsh punishment for breaching them. Overall, the voice displayed more negative than positive aspects, leading participants to finally accept help to distance it and their eating disorder. This process, however, was far from simple, with the voice lurking in the background, ready to jeopardize attempts towards recovery (Tierney & Fox, 2011). A recent meta-synthesis of qualitative studies exploring outcomes in anorexia nervosa suggests that learning to cope with the anorexic voice represents a critical step in recovery (Duncan et al., 2014). In addition, the anorexic voice appears to play a role in relapse, whereby individuals may be encouraged to return to eating disorder behaviour (Fox et al., 2012).

Further quantitative studies about the anorexic voice were conducted in the years that followed. Pugh & Waller (2016) found that a more powerful anorexic voice was associated with more negative eating attitudes and suggested that the anorexic voice may function as a maintenance factor in anorexia nervosa. They also indicated as suggestions for further research to investigate whether this voice is also found in other eating disorders (Pugh & Waller, 2016).

In a follow-up study, Pugh & Waller (2017) developed a refined research design, aiming at a model of the anorexic voice, which, in turn, may be relevant to key features of eating disorder pathologies. Two subgroups emerged with weaker and stronger voice experiences. Those with stronger voices described more negative eating attitudes, more severe compensatory behaviours and a longer duration of illness. Furthermore, participants that perceived the voice as benevolent displayed more pathological eating attitudes and those who perceived the voice as omnipotent displayed a longer duration of illness. Overall, the severity of key elements of eating pathology was influenced by appraisals and responses to the anorexic voice (Pugh & Waller, 2017). This may indicate that treatment approaches aimed at re-evaluating how the voice is perceived and responded to by patients can have an impact on eating disorder severity.

Further research on the critical inner voice in a therapeutic context can also aid our understanding of this phenomenon. Stinckens et al. (2013) hold that the critical inner voice forms an essential characteristic of various psychological disorders, including eating disorders.

They carried out a systematic analysis of a varied sample of therapy episodes in which the critical inner voice was present and reviewed existing literature on the subject. This led to a taxonomy of various manifestations of the critical inner voice, including the degrading/undermining critic, the punitive/accusatory critic, the overdemanding/controlling critic, the subservient/neglectful critic, the distant/avoidant critic and the domineering/compensating critic. As their review was not exclusively related to eating disorders, it will be interesting to observe whether similar types of critical inner voices emerge from the present study.

It is Noordenbos et al. (2014), who conducted a quantitative study focusing on the critical inner voice across eating disorders. Their research design aimed at investigating whether eating disordered individuals heard critical inner voices significantly more often than individuals in the general population. Participants were assigned to the eating disorder group if they had been diagnosed with an eating disorder but did not present with psychotic symptoms to ensure that the inner voices heard by participants were not hallucinations. The group included seventy-four females with a range of diagnoses and at different stages of recovery. The control group consisted of fifty-eight females with no clinical diagnosis of eating disorders or any psychotic disorder. All participants were asked to complete a battery of questionnaires regarding hearing voices, self-esteem, self-criticism and eating disorder symptoms. Results showed that 94.5% of the eating disorder group reported hearing critical inner voices whereas only 29.3% of the control group experienced hearing these. Statistical tests demonstrated that the likelihood of hearing a critical inner voice differed significantly between the two groups. Individuals in the eating disorder group also experienced hearing critical inner voices with significantly higher frequency than normal individuals. Participants in the eating disorder group who heard a critical inner voice reported hearing it at least once a week and 21.4% heard it almost continuously. On the other hand, in the control group only 33.3% heard the voice once a week and none of them heard it continuously.

The above findings indicate that critical inner voices are a key feature of not only anorexia nervosa but also other eating disorders, therefore, it would be helpful to further investigate this phenomenon across all eating disorders. Research also indicates that service users with eating disorders desire a greater awareness of the critical inner voice by professionals (Davies, 2008).

Although the anorexic voice has been studied from both a quantitative and a qualitative perspective, the critical inner voice across all eating disorders has only been studied from a quantitative perspective. In contrast, the current study aims to investigate this phenomenon using a qualitative methodology, looking at participants' accounts from an in-depth, phenomenological perspective. This research aims to investigate the experience of the critical inner voice in eating disorders and to explore its implications for treatment.

1.4. Treatments for Eating Disorders

This research aims to enhance the understanding of the critical inner voice in eating disorders and to inform clinical practice. Therefore, it feels relevant to introduce several treatment approaches that may be applied to the treatment of eating disorders and the critical inner voice specifically.

Recent advances in the understanding of the aetiology of eating disorders have considerably improved the treatment options available (McGilley, 2006). Nevertheless, nearly half of eating disorder patients experience a chronic or unremitting illness (Steiner & Lock, 1998). A review of treatment outcomes for anorexia nervosa reports that, of all patients diagnosed, 20% remain chronically ill and 63% relapse (Steinhausen, 2002). Similarly, individuals with bulimia nervosa or binge eating disorder have a recovery rate of 50% following treatment (Wilson et al., 2007).

The National Institute for Clinical Excellence (NICE) published a guideline to advise clinicians on the treatment of eating disorders after careful consideration of the evidence available. The guideline was developed by a multidisciplinary team and is intended to be taken into account by professionals alongside the individual needs and preferences of patients (NICE, 2017). The recommended treatment for eating disorders is based on a team approach which includes the patient, family members or carers and mental health professionals such as psychiatrists, dieticians, nurses and psychologists (Kreipe et al., 1995; Weltzin et al., 2014). The guideline was published in 2004 and reviewed in 2011 but NICE concluded that no further evidence had been found regarding the treatment of eating disorders and therefore decided not to update the guideline (NICE, 2004; NICE, 2011). The guideline was ultimately reviewed in 2017 resulting in a new publication (NICE, 2017).

For adults with anorexia nervosa, the guideline recommends individual eating-disorder-focused cognitive behavioural therapy (CBT-ED), Maudsley Anorexia Nervosa Treatment for Adults (MANTRA) or specialist supportive clinical management (SSCM). Should these treatments be unacceptable or ineffective, eating-disorder-focused focal psychodynamic therapy (FPT) may also be considered.

Psychological treatment of bulimia nervosa in adults, according to the NICE guideline, should initially entail bulimia-nervosa-focused guided self-help. Should this be ineffective after 4 weeks of treatment, individual eating-disorder-focused cognitive behavioural therapy (CBT-ED) should be considered.

Similarly, individuals suffering from binge eating disorder are recommended to initially engage in a binge-eating-disorder-focused guided self-help programme or alternatively a group or individual intervention based on eating-disorder-focused cognitive behavioural therapy (CBT-ED).

For people with other specified feeding and eating disorder (OSFED) the NICE guideline recommends using the treatment for the eating disorder it most closely resembles.

Different treatments may be more effective for children and young people. Family therapy is recommended for anorexia nervosa and bulimia nervosa, as well as CBT-ED. Adolescent-focused psychotherapy (AFP-AN) is also recommended for anorexia nervosa (NICE, 2017). For binge eating disorder, the treatment is the same as for adults.

As this study is focused on the experience of the critical inner voice in all eating disorders, it feels appropriate to describe in more detail treatments that apply to all disorders within an adult population and that are deemed relevant to the critical inner voice. I will therefore outline and present evidence for eating-disorder-focused cognitive behavioural therapy (CBT-ED), as the primary treatment outlined in the NICE guideline that spans all eating disorders. In addition, I will review treatments that are mentioned by participants in their interviews. These are Acceptance and Commitment Therapy (ACT), Compassion Focused Therapy (CFT) and Mentalisation Based Therapy (MBT). Furthermore, I will describe Emotion Focused Therapy (EFT), as it provides a framework for addressing the critical inner voice specifically. For each approach, I will attempt to outline how the critical inner voice may be conceptualised and addressed.

Eating Disorder Focused Cognitive Behavioural Therapy (CBT-ED)

The term CBT-ED encompasses all CBT based approaches for eating disorders. The NICE guideline highlights the key treatment features which are particularly relevant to each eating disorder. Programs for anorexia nervosa in adults should typically consist of up to forty sessions and aim to reduce risk to physical health and behavioural symptoms of the eating disorder, encouraging healthy eating and reaching a healthy body weight (NICE, 2017). They may cover nutrition, cognitive restructuring, mood regulation, social skills, body image, self-esteem and relapse prevention (NICE, 2017). CBT-ED for bulimia nervosa should last for up to twenty sessions and should include psychoeducation and behavioural interventions (NICE, 2017). CBT-ED treatment for binge eating disorder should consist of up to twenty sessions, include a formulation of the persons' psychological issues and how they relate to binge eating behaviour.

It may also encompass dietary advice, cognitive restructuring and behavioural experiments (NICE, 2017).

Cognitive Behavioural Therapy (CBT) is based on the concept that thoughts, emotions, behaviour and physiology are part of an interrelated system and therefore changes to one element will affect the others (Curwen et al., 2000). It assumes that psychological problems are caused by maladaptive thinking and behaviour so that by identifying and challenging these, psychological change can happen (Padesky & Greenberger, 1995). Although CBT acknowledges that psychological problems are often rooted in developmental experiences, its primary focus is addressing problems in the present (Westbrook et al., 2011). CBT approaches have been used as treatment for eating disorders since the 1980s. Some of the earliest adaptations for eating disorders were introduced for the treatment of anorexia nervosa (Garner & Bemis, 1982) as well as bulimia nervosa (Fairburn, 1981). In subsequent years treatments for binge eating disorder were also explored (Agras et al., 1997). A CBT protocol for eating disorders was specifically developed by Fairburn (2008) – Enhanced CBT (CBT-E), it is based on the premise that there are common cognitive mechanisms that underlie all eating disorders, primarily the over-evaluation of shape and weight and their control. This approach focuses on psychoeducation, enhancing other domains for self-evaluation, reducing shape checking and dietary rules, understanding the effects of mood on eating behaviour and establishing a pattern of regular eating (Fairburn, 2008).

Recent studies suggest that CBT-ED approaches could provide effective treatment for adults diagnosed with anorexia nervosa. Fairburn et al. (2013) found that significant weight gain and reduction in eating disorder pathology were achieved in two thirds of adult patients and these improvements were also maintained at follow-up. The effectiveness of CBT-ED approaches for bulimia nervosa is well established (e.g. Brown & Keel, 2012; Chen et al., 2003). Findings suggest that symptom remission is achieved in 40-50% of cases, with symptom reduction in 60-70% of individuals (Pike et al., 2015; Wilson, 1999). With regards to binge eating disorder, there is also good evidence for the use of CBT-ED approaches (e.g. Brownley et al., 2016; Treasure et al., 2010).

The closest concept to the critical inner voice which may be found within a CBT approach is that of “negative automatic thoughts”, which may be critical, judgmental or rigid. CBT therapists support individuals to identify and evaluate these dysfunctional cognitions through techniques like guided discovery and behavioural experiments, eventually aiming to replace them with more helpful or realistic cognitions (Beck, 2011). A key difference between these thoughts and the critical inner voice is that the voice is likely to be experienced as more separate from the self, potentially speaking to individuals in the second person rather than the first. Existing

research outlined earlier in the chapter also highlights different functions of the critical inner voice, such as behavioural instructions and motivation. Nevertheless, cognitive restructuring techniques may be helpful in dealing with certain aspects of the critical inner voice, as well as underlying assumptions and core beliefs.

Acceptance and Commitment Therapy (ACT)

ACT is a “third wave” cognitive behavioural approach in that it integrates a basic science, learning and behaviour theory perspective with an emphasis on mindfulness and acceptance of internal events that cannot be changed (Hayes et al., 1999). ACT, as the name suggests, has a core aim to accept what is out of personal control and commit to taking values-guided actions. ACT teaches clients to develop mindful self-acceptance, clarify personal values and create goals that can lead to a more fulfilling life (Juarascio et al., 2013). The theory behind ACT sustains that, thanks to human language and the sophistication of the mind, humans have the capability to experience thoughts and feelings relating to past and future events as well as present ones. Because of this, human lives inevitably involve significant pain which typically is handled ineffectively (Harris, 2009). ACT focuses the processes behind clients’ distressing experiences and psychopathology, rather than on the content of their maladaptive cognitions or behaviours. It seeks to weaken the link between unpleasant internal experiences and subsequent maladaptive behaviour, without necessarily altering the internal experiences themselves. Thus, clients learn to identify and mindfully observe feelings and thoughts without responding to them (Berman et al., 2009). The overarching goal of ACT is to increase clients’ psychological flexibility, which includes the awareness and acceptance of difficult internal experiences as well as acting in accordance with their own identified goals and values. Such mindful, values-congruent living is the desired outcome in ACT, so, although ACT typically reduces symptoms, this is not the explicit goal (Harris, 2009).

A recent study investigated the efficacy of an ACT based group treatment for eating disorders compared to treatment as usual within an inpatient population and found trends towards larger decreases in eating pathology among those receiving ACT. ACT clients also showed lower rates of rehospitalisation (Juarascio et al., 2013). One day ACT workshops for clients with problematic eating behaviours and body image concerns have also shown promising results. There were significant decreases in body image dissatisfaction, disordered eating symptomatology, thought suppression and experiential avoidance (Clark, 2014; Walloch, 2014).

From the perspective of ACT, the critical inner voice would be regarded as being linked to the capacity for language. It is because of this capacity that people can develop a critical inner voice

in the first place, and this can cause considerable unnecessary pain. As a cognitive process, the critical inner voice would be addressed by encouraging “defusion”. “Fusion” means getting caught up in our thoughts and allowing them to dominate our behaviour, whereas “defusion” means distancing our thoughts, letting them come and go instead of focusing on them (Harris, 2009). ACT typically employs practical exercises and metaphors to demonstrate fusion and defusion. ACT would aim for clients to be able to mindfully observe the critical inner voice and to weaken the link between it and unhelpful behaviour, without aiming to alter the content of the voice itself. The focus on values guided action may also help clients to evaluate their values and contrast these with values that are encouraged by their critical inner voice.

Compassion Focused Therapy (CFT)

CFT is also a “third wave” cognitive behavioural approach and was originally developed as a treatment to target shame, self-criticism and self-directed hostility. These are important maintaining factors in several mental health difficulties (Goss & Allan, 2014), including eating disorders (Goss & Allan, 2009). Shame, self-criticism and self-directed hostility can be addressed via the development and practice of compassion (Gilbert, 2009; 2010). This involves three processes: being open to helpfulness and compassion from others, towards others, and developing an encouraging, supportive, and compassionate approach to oneself (Gilbert, 2014). The philosophical position of CFT arises from three “reality checks” which are used to offset pathologizing (Gilbert, 2010). Firstly, our evolved brains are difficult and not well designed - our “new brain” competencies for thinking, reflection and self-awareness can interact with more basic “old brain” functions and cause psychological problems. Secondly, our lives are relatively short and often involve dealing with tragedies (threats, losses, diseases). In addition, our mind can cause suffering long after difficult events because of elaborate cognitive functions. Thirdly, our social circumstances play a large role in how our brains and self-identities mature since birth and we have very little control over this (Gilbert, 2010). The awareness of such realities summons up the importance of compassion – the need to be open to suffering with a desire to relieve suffering for ourselves and others. CFT also emphasises that we have the responsibility to deal with our difficult lives and brains as best as we can, despite the fact that they are not our fault (Gilbert, 2010).

A specific CFT protocol was developed for the treatment of eating disorders, Compassion Focused therapy for Eating Disorders (CFT-E) (Goss & Allan, 2014). Having developed out of a CBT group-based protocol, CFT-E retains some CBT interventions including guided discovery, graded exposure and behavioural experiments (Goss & Allan, 2014). In addition, the unique emphasis on the evolutionary model of affect regulation highlights how the human brain and

body have evolved to make the regulation of emotion, eating and weight difficult. It also focuses on helping individuals foster the ability to experience and use pleasurable emotions to manage feelings of anxiety, anger, grief and disgust (Goss & Allan, 2014).

Evidence for the effectiveness of CFT for eating disorders has been encouraging. Outcome research shows significant improvements on self-reported eating disorder symptoms (Gale et al., 2012). Those diagnosed with bulimia nervosa benefited the most, with three quarters considered recovered by the end of treatment, whereas those with anorexia nervosa benefited the least. Nonetheless, a third were considered recovered and an additional quarter had symptoms in the non-clinical range by the end of treatment. The relatively poor outcomes for anorexia nervosa need to be considered in the context of the lack of evidence for any other effective group treatment (Leung et al., 1999).

CFT would address the self-critical element of the voice directly, as it was specifically developed to target self-criticism and self-directed hostility by encouraging the development of self-compassion. CFT conceptualises self-criticism in terms of critical comments, dialogues and feelings within the self. It also differentiates between two types of self-criticism, one which involves feeling inadequate and another which relates to hatred of the self (Gilbert, 2010). The approach suggests exploring the individual experience of self-criticism – how it began and developed over time, what functions it serves and what it protects against (Gilbert, 2010). CFT includes the practice of mindfulness and imagery based exercises to help the development of self-compassion. Neff (2009) proposes that there are three components to self-compassion: self-kindness, that is, thinking about oneself with warmth and understanding rather than in a critical or judgmental way; a sense of common humanity, that is, being aware that all human beings are fallible and that mistakes, suffering, and unfairness are part of the human condition; and mindfulness of one's present experience, so that one neither ignores nor ruminates on disliked aspects of oneself or one's life. The development of self-kindness may specifically address the aspect of the voice which encourages punitive and self-destructive behaviours, by instead focusing on self-care and non-judgment.

Mentalisation Based Therapy (MBT)

MBT is an integrative approach, bringing together aspects of psychodynamic, cognitive-behavioural, systemic and ecological approaches. It was initially developed for individuals with borderline personality disorder (Bateman & Fonagy, 2010). It centres around the idea that when mentalising is compromised, internal experiences and interpersonal interactions stop making sense and this leaves individuals vulnerable to rapidly changing emotional states and impulsivity

(Daubney & Bateman, 2015). Mentalising is the process by which we make sense of each other and ourselves, it is a dynamic process with particular relevance in attachment relationships. Without mentalising there can be no robust sense of self or mutuality in relationships (Daubney & Bateman, 2015).

Traditionally, MBT programs are organized around an 18-month period including weekly individual and group sessions, crisis planning and integrated psychiatric care. The treatment begins with assessment, formulation and safety planning and is a very collaborative process. The presenting problem is discussed in terms of difficulties in mentalising and its impairment (Daubney & Bateman, 2015). A key component of MBT is the therapeutic stance which emphasizes humility, a sense of knowing and taking time to identify differences in perspective. The therapist is continuously constructing and reconstructing an image of the patient to help them understand what they feel (Daubney & Bateman, 2015). A number of core MBT techniques and interventions have been defined. They are support/empathy, clarification, elaboration, challenge, basic mentalising and identifying affect focus, and mentalising the relationship. These are applied as relevant in the service of the overall treatment goals of regulating affect and reinstating mentalisation (Daubney & Bateman, 2015).

Impaired mentalisation has been found to be a central psychopathological feature in anorexia nervosa (Skarderud, 2007) and a specific MBT protocol for the treatment of eating disorders was developed and tested using a randomized control trial and found to be effective (Robinson, 2014). It was observed that breaks in mentalisation due to unbearable emotional states can often be linked to the onset and maintenance of eating disorders. It was also found that eating disorder symptoms can be linked to problems in relationships and that tracing these links was found helpful by patients. It therefore seems that MBT may prove to be a useful approach in the treatment of eating disorders (Robinson, 2014).

MBT is particularly relevant to the aspects of the critical inner voice which involve social interactions or others' opinions as these can be directly related to a lack of mentalising capacity. MBT can also help to distinguish between bodily sensations and mental representations, so that body image and appetite concerns can be explored and understood, rather than continuing to fuel the critical inner voice.

Emotion Focused Therapy (EFT)

Emotion Focused Therapy (EFT) is a neohumanistic approach designed to help clients become aware of and make productive use of their emotions. It is based on two main treatment

principles: the provision of an empathetic therapeutic relationship and the facilitation of therapeutic work on emotion (Greenberg et al. 1993). According to EFT, the healthy self has a capacity to identify, interpret and be guided by adaptive emotional experiences and to respond to them appropriately. Dysfunction is construed as resulting from being caught in rigid patterns of activation of maladaptive emotion schemes that cause psychological pain (Dolhanty & Greenberg, 2009). A key notion behind EFT is that a person needs to experience emotion in order to be informed and moved by it and to make it accessible to change. People change emotions by accepting and experiencing them and ultimately can transform them to create a new narrative meaning (Greenberg, 2015). Change in EFT is understood as emerging from this experiential processing, in the form of greater acceptance of the self and of internal experiences, as well as restructuring of maladaptive emotional responses. Acceptance entails a shift from a negative evaluation of one's emotional experiences to a more self-accepting stance (Dolhanty & Greenberg, 2009).

Formulation and treatment in EFT include eight steps. Identifying the presenting problem, exploring the client's narrative about the problem, gathering information about the client's attachments, observing and attending to the client's way of processing emotions, identifying and responding to the painful aspects of the experience, identifying markers and suggesting tasks to resolve problematic processes, focusing on thematic intrapersonal and interpersonal processes, attending to the client's processing to guide interventions within tasks (Greenberg & Goldman, 2007). In the initial three steps the therapist uses empathic responding and coaches clients to explore and articulate how their difficulties fit into their broader life narrative. In the remaining steps the therapist makes process diagnoses and engages the client in processing tasks. EFT has as a goal the processing of painful emotions, ultimately to transform maladaptive emotions with the activation of healthy innate emotions (Dolhanty & Greenberg, 2009).

EFT has been proposed as highly suited to the treatment of eating disorders (Dolhanty & Greenberg, 2007). It offers specific techniques to facilitate the expression of aspects of emotional experience that eating disordered individuals tend to inhibit (Geller et al., 2000). In eating disorders, an impaired capacity to access and be guided by healthy emotions results in a perception of emotional experience as overwhelming and the need for the eating disorder as a means of avoiding emotions (Dolhanty & Greenberg, 2009). Formulation and interventions facilitate recovery by encouraging replacement of the eating disorder as a means of managing affect with more adaptive emotional responses (Treasure et al., 2000).

Evidence for the efficacy of EFT in the treatment of eating disorders is limited but encouraging. A group EFT approach was employed with patients diagnosed with bulimia nervosa, binge-eating disorder and eating disorders not otherwise specified. Outcome data showed significant

changes in binge eating and general eating pathology measures. Participants also reported improvements in mood, emotion regulation and self-efficacy (Wnuk et al., 2015). Individual EFT also showed good outcomes in treating binge-eating disorder. A small-scale study reported reliable recovery from binge-eating psychopathology and a significant decrease in binge-eating frequency. In addition, there was reliable improvement or recovery on eating and shape concerns, overall emotion regulation, depression and anxiety (Gilsenti et al., 2018).

EFT encourages a relational approach to internal voices (Dolhanty & Greenberg, 2009). Gestalt chair work is used to facilitate resolving internal splits involving the critical inner voice. Dealing with such splits falls under the sixth step of treatment (identifying markers and suggesting appropriate tasks to resolve problematic processes). Conflict splits occur when a part of the self is critical or coercive towards another part of the self and are processed by means of a two-chair dialogue. The parts of the self “speak” to each other with the goal of determining the impact and function of the critical inner voice (Dolhanty & Greenberg, 2009).

I hope that outlining relevant treatment approaches will provide a basis for discussion about the experience of the critical inner voice and how it may be understood and addressed in clinical practice. The above approaches include a variety of clinical interventions that may be applied to the critical inner voice. It will be interesting to notice what participants say in regard to how the critical inner voice is addressed in therapy.

1.5. Conclusion

Summary of the Literature Review and Rationale for the Study

Eating disorders are challenging to treat and have increased in prevalence in recent years (B-eat, 2017). About 15% of people with an eating disorder have anorexia nervosa, whereas most others meet diagnostic criteria for bulimia nervosa, binge eating disorder, or other specified feeding and eating disorders (NICE, 2017). Eating disorders share a core psychopathology whereby most individuals display the over-valuation of shape and weight and their control (Fairburn, 2008) and they can arise as a result of biological, emotional, social, interpersonal and psychological factors (Polivy & Herman, 2002). Although eating disorders manifest themselves through a preoccupation with diet and body image, they are often a symptom of underlying difficulties (Gowers & Shore, 2001) including feelings of self-hatred, inadequacy and shame (Rance et al., 2017). Existing qualitative research on eating disorders shows some commonalities in how they are experienced. Participants describe eating disorders as having the quality of an external entity, separate from themselves (Ross & Green, 2011). They describe a mental and

psychological battle within themselves (Broussard, 2005; Cranston, 2011). These features are linked to the presence of the critical inner voice, which has been identified as a key component of the eating disorder experience in several accounts (Brook, 1978; Claude-Pierre, 1997; Kortink, 2008, Fathallah, 2006; Hendrix, 2003; Higbed & Fox, 2010; Nottelman & Thijssen, 2010).

The phenomenon of the critical inner voice experienced by individuals with eating disorders is closely linked to what many of us experience as inner speech and may even be an aspect of inner speech which has become particularly prominent in individuals with eating disorders. Inner speech is thought to play an important role in the self-regulation of cognition and behaviour in children and adults (Alderson-Day & Fernyhough, 2015) and has attracted investigation from disparate fields such as developmental psychology, cognitive neuroscience and psychopathology. The phenomenology of inner speech has been primarily studied using questionnaires and experience sampling (Alderson-Day & Fernyhough, 2015), rather than qualitative methodologies. There has also been little focus on the interplay between experiences of inner speech and mental health problems.

Qualitative research on the critical inner voice has been instrumental in shedding light on how this phenomenon manifests. However, it remains limited and mostly focused on anorexia nervosa (Wade, 2003; Tierney & Fox, 2010; Tierney & Fox, 2011). Quantitative studies have also been mostly – yet not only – focused on anorexia nervosa. A more powerful anorexic voice was found to be associated with more negative eating attitudes, which suggested that it may play a key role in anorexia nervosa (Pugh & Waller, 2016). Those with stronger voices also described more negative eating attitudes, more severe compensatory behaviours and a longer duration of illness (Pugh & Waller, 2017). One quantitative study established that individuals presenting with any eating disorder hear critical inner voices significantly more often than individuals in the normal population (Noordenbos et al., 2014). The present study aims to build on these findings by providing an in-depth qualitative exploration of the phenomenon of the critical inner voice across all eating disorders. It aims to contribute to the understanding and treatment of eating disorders as well as provide a basis for further research.

Individuals may find it difficult to progress towards recovery when their critical inner voice has a tight grip over their thoughts and behaviours (Higbed & Fox, 2010). It is therefore important to better understand the experience of such voice, so that it can be addressed in treatment. Several approaches are recommended for the treatment of eating disorders (NICE, 2017) and more are used in practice, with a growing body of evidence. Each approach may conceptualise and address the critical inner voice in different ways and it will be interesting to note their relevance to and interaction with the critical inner voice following the analysis of participants' accounts.

Research Aim and Research Questions

This study plans to explore the phenomenon of the critical inner voice which is often experienced by individuals with eating disorders. This voice may manifest itself in different ways – it may judge, criticize or tell individuals how to behave (Noordenbos et al., 2014). A qualitative exploration of this phenomenon hopes to shed light on how individuals make sense of their experience. This research hopes to enhance the understanding of the critical inner voice for clinicians and clients, and to inform clinical practice.

The following research questions will be kept in mind throughout the study:

How do individuals affected by eating disorders experience the critical inner voice?

How can this knowledge inform clinical practice?

Contribution to Counselling Psychology

One of the primary reasons for conducting research is to make a contribution to one's discipline. This study contributes to Counselling Psychology by exploring a phenomenon which is relatively under-researched and yet widely applicable to clinical work with eating disorders.

This research hopes to contribute to the understanding of the phenomenon of the critical inner voice experienced by individuals with eating disorders, which will deepen the understanding of eating disorders as a whole and hopefully provide a basis for further academic research and clinical application. If the critical inner voice is indeed such a crucial element of eating disorder psychopathology, an in-depth exploration of this phenomenon will directly benefit clinicians' understanding of an eating disordered population. This research may provide clinicians an insight into how the critical inner voice might manifest across the whole spectrum of eating disorders and inform their practice.

This study also aims to make specific recommendations for clinical practice based on participants' experiences of their critical inner voice, which will hopefully be of value to the profession. It will therefore indirectly benefit clients themselves, as it will enable them to receive well informed interventions to target their critical inner voice.

Furthermore, the findings of this study may highlight some novel theory-practice links that can form the basis for further academic research on the critical inner voice, eating disorders or

related topics. Similarly, they may inform further development of therapeutic approaches for eating disorders or for critical inner voices generally. There is also the possibility that the findings of this research will have a broader impact on the field of Counselling Psychology due to their applicability to other areas of research and practice.

Chapter 2: Methodology

2.1. Introduction

This study explores the phenomenon of the critical inner voice experienced by individuals with eating disorders. This voice can manifest itself in different ways – it may judge, criticize or tell individuals how to behave (Noordenbos et al., 2014). A qualitative exploration of this phenomenon hopes to shed light on how individuals make sense of their experience. This will be a qualitative study employing interpretative phenomenological analysis (IPA) as a methodology.

This chapter aims to provide a description of the methodological approach used in answering the research question. I will outline the reasons for my choice of methodology and my epistemological standpoint. A detailed description of my research design will then be given, followed by reflexivity and ethical considerations.

2.2. Methodological Approach

Rationale for Choice of Methodology

A qualitative methodology seemed most appropriate for my research question since it is conducive to capturing how participants make sense of their critical inner voice and what it means to them. A qualitative study seeks to describe and possibly interpret experience rather than quantify phenomena or determine any statistically significant relationships between them. It therefore seemed suitable for an exploratory study looking at the critical inner voice as a unique experience to be revealed through the accounts of participants. Qualitative research is driven by a focus on meaning (Willig, 2012) which is subjective and derived from participants' accounts of their experience. The fact that qualitative research is grounded in lived experience means that it is more likely to respect the unique meanings of participants (Kitzinger, 1990). The inductive process of qualitative research allows to give voice to participants' experience in a more personal and less controlled way than in quantitative studies (Willig, 2012).

IPA was chosen because of its focus on meaning-making processes for participants as well as for the researcher. When it comes to understanding the experience of the critical inner voice, I believe it is interesting to focus on how it manifests but also on its meaning for participants in

the context of their lives. This methodological approach further allows the researcher to co-construct meaning during data collection and analysis. Allowing for this interpretative and interactive aspect is particularly important since, as a researcher, it is not possible to completely bracket my own clinical and lived experience of self-criticism and eating disorders. IPA accepts that knowledge is co-constructed by the researcher and participant but also holds that there is an empirical world out there to be respected (Willig, 2001). I believe that this tension between phenomenology and interpretation is particularly relevant to such a specific and abstract phenomenon as the critical inner voice, and can lead to richer results than a simply descriptive approach. Furthermore, the pluralism and epistemological freedom of IPA enables multiple levels of interpretation, as well as being open to various theoretical underpinnings (Larkin et al., 2006), once again leading to a deep and multi-faceted analysis of participants' accounts.

IPA is claimed to be particularly suited to investigating novel topics regarding the subjective experience of individuals and issues of identity and self-concept (Smith, 2004). The critical inner voice could be seen as an aspect of the self, making IPA the ideal approach to investigate this phenomenon. Smith et al. (2009) note that IPA is also increasingly being used to examine the experience and context of psychological distress (Dunkley et al. 2015; Kiamanesh et al. 2015). It has proven particularly useful to explore metaphorical representations of distress in psychosis (Latif et al., 2004), I therefore hope it will similarly illuminate the phenomenon of the critical inner voice and how individuals with eating disorders experience it.

An alternative choice of methodology could have been discourse analysis. Such an approach to research is based on the assumption that all human experience is mediated by language and therefore all social and psychological phenomena are constructed (Willig, 2012). The researcher is interested in how discourses are deployed by the participant and how these may shape the participant's experience (Willig, 2012). Whilst I do consider that reality is partly socially constructed and that language plays an important role as a mediator of experience, this project is mostly focused on illuminating internal thoughts and experiences in their own right, not the ways in which social constructions could be drawn from the participants' accounts. Furthermore, as the experience of the critical inner voice is rooted in language by definition, I thought it would be more appropriate to employ a methodology that does not further consider the role of language, as this would add too many layers to the analysis. Having made this choice of methodology, I nevertheless acknowledge that the experience of the critical inner voice is likely to be heavily influenced by language and by participants' social context.

Epistemological Framework

IPA is compatible with a wide range of research paradigms and ontological and epistemological positions (Larkin et al., 2006). In what follows I will describe my personal standpoint which I adopted within this research study.

I have chosen to adopt an interpretative-constructivist research paradigm. This adheres to a relativist position in that it assumes the existence of multiple and equally valid experiential realities (Ponterotto, 2005). According to this paradigm the goal of research is to understand the lived experience from the point of view of those who live it (Schwandt, 2000). When looking at an internal process such as the critical inner voice, it seems that approaching it from this point of view would be most reasonable. As far as internal experiences are concerned, there can be no objective reality but only the subjective internal reality of participants experiencing a unique phenomenon. Additionally, I believe that the interpretative-constructivist paradigm is one that can be particularly useful in the context of counselling psychology since the process of co-constructing meaning is one of the main activities conducted by counselling psychologists during therapy, particularly when addressing psychological phenomena such as the critical inner voice. It is therefore important that this process is acknowledged and reflected on from a research perspective.

Constructivists hold that experiential reality is constructed in the mind of the individual rather than it being an external entity (Hansen, 2004). As a result, we can only know about lived experience from the point of view of those who live it. This is particularly true for an internal experience like the critical inner voice. Furthermore, constructivists hold that the researcher and participants jointly create findings from their interactive dialogue and interpretation (Ponterotto, 2005). As a consequence, researcher values and lived experience cannot be divorced from the research process. The constructivist position is compatible with a hermeneutical approach, which maintains that meaning is hidden and must be brought to the surface through deep reflection (Schwandt, 2000). This reflection can be stimulated by the interaction between researcher and participant and only through this interaction can deeper meaning be uncovered (Ponterotto, 2005). Such an approach aspires to give meaning to participants' experiences beyond that which the participants may be able or willing to attribute to it. It is therefore possible to extract meanings that are not obvious to even the person who has produced the account (Willig, 2012). When approaching a subject like the critical inner voice, it seems crucial to maintain openness to different layers of meaning and interpretation. Allowing for co-construction of meaning through interactive reflection and analysis will produce a rich and varied account of the critical inner voice.

As previously mentioned, an interpretative-constructivist standpoint is compatible with a relativist ontology – the belief that there exist multiple constructed experiential realities rather

than a single true reality. According to this position, experiential reality is subjective and influenced by the context of the individual's experience and perceptions, their perceived social environment, and the interaction between the individual and the researcher (Ponterotto, 2005). As a researcher looking at a phenomenon which manifests itself internally, it seems logical to adopt a relativist position towards the data, as no direct proposition can be made about whether what participants are reporting is true or not. Participants' accounts are of interest not because they inform the researcher about what is real but rather because they tell something about how participants are constructing meaning within their lives (Willig, 2012). The aim of the research is not to uncover the truth but to gain a better understanding of the participants' internal experiences and meaning-making activities.

The existence of multiple individual realities can also be compatible with either a social-constructionist or phenomenological epistemology, and I have chosen to incorporate both in my study. Hansen (2004) proposes that a meta-epistemic system which encompasses more than one position can be feasibly achieved if the singular epistemic systems are considered variants of human experience.

According to a social-constructionist epistemology, the social context within which human experience takes place contributes to the participants' ways of constructing their accounts of reality. The self and identity are constructed within social situations (Eatough & Smith, 2008), therefore participants' experience of their critical inner voice cannot be isolated from the participants' social context despite the fact that it is an internal phenomenon. I would describe my stance as moderate social-constructionist – I believe experience is grounded in a socio-cultural context that shapes the ways in which individuals construct meaning (Willig, 2012). Whilst assuming that a material reality exists, each participant constructs their version of it in the process of perception and communication (Eatough & Smith, 2008).

To some extent, this research also adheres to a phenomenological epistemology, as it relates to the subjective experience of the research participants (Willig, 2012). The task of the researcher according to this epistemic position is to get as close as possible to the participants' experience and to enter their world. In a way this is similar to the role of a person-centred therapist who listens empathically, without judging and without questioning the external validity of what participants are saying (Willig, 2012). I attempted to adopt this stance whilst being aware that it is not possible to completely bracket my knowledge and experience as a researcher and clinician, leading to an interpretative phenomenological position, which allows for the co-construction of meaning in the research process. The interpretative phenomenological underpinnings of my epistemic standpoint will be described in more detail in the following section on IPA, as they are closely linked with my choice of methodology.

Interpretative Phenomenological Analysis (IPA)

IPA is a qualitative research method rooted in phenomenology and developed by Jonathan Smith (1997). It is primarily concerned with how humans experience and make sense of the world around them (Willig, 2001). The phenomenological aspect of IPA gives voice to the participants' reality, whilst the interpretative element allows for the researcher to elaborate and contextualize their experiences from a psychological perspective (Larkin et al., 2006). This combination is particularly suited to examining such a personal and psychologically laden phenomenon as the critical inner voice of individuals with eating disorders. The overarching aim of IPA is to conduct a systematic exploration of consciousness, personal experiences and the process of understanding and reflecting on them (Smith et al., 2009). Furthermore, the individual experience is seen as embedded and immersed in a world of objects and relationships, language and culture, projects and concerns (Smith et al., 2009).

The theoretical foundations of IPA are grounded in three key areas of the philosophy of knowledge: phenomenology, hermeneutics and idiography (Smith et al., 2009).

Phenomenology concerns the study of experience and its perception. IPA is phenomenological in that it is primarily concerned with a deep exploration of participants' lived experience. It is influenced by philosophers such as Husserl (1927) and Heidegger (1927, 1962). Husserl (1982) advocated that science should be grounded in personal experience and that only through attentive systematic examination of awareness, second-order concepts and theories could be developed. He also acknowledged the difficulty in maintaining a neutral stance, as it would require that we remove our pre-conceptions and our habitual ways of viewing phenomena. IPA also takes on board Husserl's proposition that experience involves first order activity as well as second order reactions to that activity in the form of mental and emotional processing about those experiences (Husserl, 1927). This study is embedded in a phenomenological approach as it involves the exploration of participants' subjective experiences of the critical inner voice. Arguably it would be impossible to produce an objective record of the experience, due to its internal and abstract nature.

Hermeneutics is the theory of interpretation. It acknowledges that direct access to experience is not possible and that we can only explore it through the process of making sense of that experience – by the participants and then by the researcher (Smith et al., 2009). It follows that the phenomenology adopted by IPA is not purely descriptive like that which underpins other phenomenological approaches (Giorgi, 1992). Rather, according to Heidegger's approach to phenomenology, IPA draws on hermeneutics, proposing that it is through our interpretation, or

how things appear to us, that we can investigate and understand lived experience (Smith et al., 2009). In IPA research, our attempts to understand other people's relationship to the world are necessarily interpretative and will focus upon their attempts to make meaning out of their activities and events in their lives. In a way, IPA attempts to understand the participants' life-world in a similar fashion to knowing the client in a therapeutic encounter (Child, 2007). During this process a "double hermeneutic" is involved – the participants are trying to make sense of their world and the researcher is trying to make sense of the participants trying to make sense of their world (Smith & Osborn, 2003). Within this double hermeneutic the researcher is both empathic and questioning – simultaneously trying to inhabit the participants' perspective and aiming to illuminate their experience using psychological knowledge and theory (Smith et al., 2009). In this study, the interpretation of the participants' experiences therefore involves a two-stage process – the participants' meaning-making activities relating to the critical inner voice and the researcher's perspective in making sense of them.

Idiography is concerned with the particular, as opposed to attempting to make claims at the group or population level that may be generalizable. It follows that the process of analysis in IPA is committed to detail and depth and to understanding how experiential phenomena are seen from the perspective of particular people in a particular context (Smith et al., 2009). It focuses on particular experiences and unique processes that may tentatively inform us about wider experiences (Smith et al., 2009). According to Smith et al. (2009), only through this detailed process can we produce psychological research which does justice to the complexity of human psychology itself (Smith et al., 2009). This study employs an idiographic approach as it attempts to look at the subjective experiences of the critical inner voice from the perspective of individual participants diagnosed with eating disorders.

In conclusion, IPA aims to investigate participants' subjective experience but it recognizes that such an exploration must necessarily implicate the researcher's own view of the world as well as the nature of the interaction between researcher and participant. As a result, the phenomenological analysis produced by the researcher is always an interpretation of the participant's experience (Willig, 2013).

I will now outline how I carried out the study in detail, including data collection, analysis and an evaluation of the study from a methodological perspective.

2.3. Research Design

Choice of Data Collection Method

According to Smith et al. (2009), IPA is best suited to a data collection method which will encourage participants to offer a rich and detailed account of their experiences. Participants need to have the opportunity to “tell their stories, speak freely and reflectively, develop their ideas and express their concerns at some length” (Smith et al., 2009, p. 56). I decided that semi structured interviews would best enable me to answer the research question. This method tends to fit most closely with the IPA model of the relationship between researcher and participants. Interviewing facilitates engaging in a “conversation with a purpose”, where questions can be modified in the light of participants’ responses and the researcher is able to inquire after any interesting topics which may arise (Smith et al., 2009). Furthermore, the interactive context of the interview provides the opportunity to explore any ambiguous or contradictory statements as well as to encourage the sharing and elaboration of more sensitive topics (Kvale & Brinkman, 2009). Given my experience in a therapeutic context, I felt that I was equipped to interact with participants in a reflective and empathic way, allowing them to explore and expand on their experiences. I also hoped to notice if aspects on the “edge of awareness” might be productively followed up (Gendlin, 1984).

Interview Structure Development

In developing the initial interview schedule, I used guidance from Smith et al. (2009). The aim of the interview was to create a setting that permitted participants to explore and reflect on their experience, thus for the most part my role was to listen and facilitate the process. With this in mind, I developed an interview schedule that served as an aid for me to encourage participants to speak about their experience of the critical inner voice. Smith et al. (2009) suggest starting with a question which allows the participants to recount an easily accessible episode or experience so that they become comfortable talking. Thereafter, more general questions addressing the research topic can be asked followed by more detailed questions. The interview questions aimed to elicit material which stayed close to the phenomenon of the research yet allowed participants to talk about their experiences in their own way. I made sure that I remained open to following up matters as they arose and did my best to be an active participant in the interview process. A schedule with about ten open questions and prompts was prepared and largely memorized to ensure that the topic would be adequately explored (Appendix 1).

A pilot interview was conducted in order to evaluate the effectiveness of the proposed interview schedule and to develop my skills as a qualitative research interviewer. It proved difficult to find an individual to fit the participant criteria through my own network so I opted to interview a

clinician experienced in working with eating disorders who answered the questions as a real or fictional client of theirs. The interview took place at City University and lasted approximately 30 minutes. After the interview the clinician gave me feedback on my interview technique as well as on my choice of questions and on the experience of me as an interviewer. They suggested that I ask broader questions at the start of the interview rather than start by asking about the research topic directly, to allow participants to get comfortable with the interview process. They also fed back that I tend to move from one topic to another, rather than delving deeper by asking more detailed questions on the same topic. The interview schedule was revised accordingly and I noted the feedback. I also asked a colleague to interview me using the revised schedule as a guide. This was useful in terms of further refining the interview questions and also served the purpose of an initial reflexivity interview. Although I do not strictly fit the participant criteria, I do have some experience of self-criticism and negative self-talk as well as past difficulties with eating behaviour. It was helpful to be in the participants' shoes and reflect on my personal investment in the research topic. This process also enabled me to better empathize with the experiences expressed by the participants. I will further expand on this area in the Reflexivity section.

Sampling

IPA's idiographic position means that depth and detail of inquiry are a priority. There is a commitment to exploring how a phenomenon is understood from the subjective perspective of particular individuals in a particular context (Smith et al., 2009). For this reason, a relatively small and homogeneous participant group is sufficient. Smith et al. (2009) suggest a number of interviews of between four and ten at doctoral level. I decided to remain open to this range and allowed the availability of participants to dictate the final number of interviews. At the same time, I kept in mind the general tendency to encourage smaller sample sizes in the literature (Brocki & Wearden, 2006; Smith et al., 2009). Participants were recruited in a purposive sampling manner.

Participants

Smith et al. (2009) recommend that participants should be part of a homogeneous sample. By making the participant group as uniform as possible, one can consequently examine in more detail the variability within that group. They also acknowledge that the degree of homogeneity

will differ for each individual study depending on what factors are indicated as relevant inclusion criteria in the literature. As I will further outline in the below paragraph, the inclusion criteria for this study were carefully considered in light of existing literature. However, it could be argued that a more homogenous sample may have been appropriate, as will be further discussed later in this chapter, in the section named Evaluation of the Research.

I initially considered focusing my research on one eating disorder in particular, as this would make the sample more homogeneous. After reviewing the literature, however, I decided to include participants who were diagnosed with any eating disorder, as this would be more suitable for an exploratory study of a novel phenomenon. Furthermore, according to Fairburn (2008), most eating disorders have a shared core psychopathology whereby individuals display the over-evaluation of shape and weight and their control. They judge their self-worth largely, or even exclusively, in terms of their shape and weight and their ability to control them (Fairburn, 2008). This perspective has been further validated by recent research (Trottier et al., 2015, Forrest et al., 2018) and has been more thoroughly explained in the previous chapter. Due to this shared core psychopathology, the critical inner voice is likely to manifest itself in a similar way across all eating disorders.

Most research relevant to eating disorders and the critical inner voice focuses on a female population (Fenning et al., 2008; Noordenbos et al., 2014; Tierney & Fox, 2010), I therefore followed suit to keep the sample more relatable within the field of study. It would certainly be useful and interesting to include male participants at a later stage in the research path, once the phenomenon of the critical voice is more established.

Research participants were selected based on the following criteria: they were adult females with a diagnosis of an eating disorder (anorexia nervosa, bulimia nervosa, binge eating disorder or other specified or unspecified eating disorders) and reported experiencing a critical inner voice, which was described as a voice that may judge, criticize or tell individuals how to behave (Noordenbos et al., 2014).

Nine participants took part in the research study. The participants were given pseudonyms in alphabetical order according to when they were interviewed (for example, the first participant interviewed was given a pseudonym beginning with the letter A).

To understand what socio-demographic factors might be implicated in the experience of my participant group, I asked each participant to complete a questionnaire which reviewed these factors (Appendix 2).

Table 1

Summary of participant characteristics					
Name	Age	Ethnicity	Education	Occupation	Relationship status
Alice	38	White British	Undergraduate	Nurse	Single
Brenda	25	White British	Undergraduate	Marketing	Cohabiting
Clara	26	White British	Postgraduate	Teacher	Single
Diana	31	White British	Postgraduate	Doctor	Single
Erica	22	White British	Postgraduate	Marketing	In a relationship
Fiona	29	White American	Postgraduate	Waitress	Married
Grace	26	White British	Undergraduate	Administrator	Single
Holly	27	White British	A-Levels	Student	Single
Iris	24	White English	Undergraduate	Public Relations	Cohabiting

The participants all identified as white, the majority of them attained university level education and were in their late 20s to early 30s. I hypothesize that the socio-demographic homogeneity of the sample may reflect typical characteristics of individuals diagnosed with eating disorders, as I shall consider in the discussion.

Procedure

A number of clinicians working in private practice were approached and they played an active role in recruiting participants from their caseload according to the above-mentioned criteria. Participants were also recruited via the network of the eating disorders charity B-eat. They were given a copy of the recruitment flyer (Appendix 3) and the participant information sheet (Appendix 4). The information sheet was written with the aim of providing participants with detailed and transparent information about the study and what would be expected of them. Potential participants were invited to communicate their interest in participating in the research project by email or via the referring clinician. Nineteen participants made initial contact by email to arrange an interview, some lost contact or were unable to participate due to problems with timing and location. Nine participants were ultimately interviewed at City University over the course of 5 months, 8 of these participants were recruited via B-eat and 1 via private practice referral. Prior to starting each interview I asked participants to sign a consent form (Appendix 5) to show that they understood the purpose of the research and what was required of them.

The form also included consent to audiotape the interview and to the publication of material from the interview, subject to confidentiality requirements. I then asked participants to complete a questionnaire concerning demographic information (Appendix 2). Semi-structured interviews were then conducted with each participant with the interview schedule (Appendix 1) as a guide. Each interview lasted between 30 and 70 minutes. Following each interview, I made a note of my reflections and impressions on the interview. Interviews were transcribed verbatim. I then analysed transcripts by examining one interview at a time using the procedure outlined in Smith et al. (2009).

Analysis

My analysis was primarily influenced by the guidelines set out in Smith et al. (2009). I appreciated the clear and structured framework whilst remaining aware that it could be applied flexibly and creatively. IPA has been described as an iterative and inductive cycle (Smith, 2007) which continuously moves from description to interpretation and from particular to shared meaning. The overarching focus of the analysis is directed towards understanding participants' efforts to make sense of their experience and to provide a collaboratively constructed interpretation of it. Below I will describe each stage of the data analysis process.

1. Reading and re-reading

The first step of an IPA analysis involves immersing oneself in the original data by reading the transcript several times. I chose to listen to the tapes alongside reading the transcript to reacquaint myself with the experience of the interview. At the same time I noted any ideas that came to mind and that I may come back to during the next stage of analysis.

2. Initial noting

Initial notes were made alongside the text to identify potential themes and topics that were anchored in the participants' words. Smith et al. (2009) suggest making three distinct types of comments - descriptive comments focused on describing the content of what the participants said, linguistic comments focused on exploring the specific use of language by the participants and conceptual comments focused on engaging in a more interrogative and abstract level with the text. This stage and the previous one overlapped at times, especially once I became familiar with the process of analysis.

3. Developing emergent themes

My aim at this stage was to group my initial noting comments into coherent themes that were important in the transcript. These themes inevitably reflected not only the participants' original words and thoughts but also my interpretation of the text.

4. Searching for connections across emergent themes

Connections were then made among emergent themes to form clusters, mapping the relationship between themes. As suggested, I explored a number of ways to do this and the techniques I made most frequent use of were as follows: abstraction, subsumption, polarisation, numeration. Abstraction involved considering whether a number of themes could be grouped under a new overarching theme. Subsumption was used where an emergent theme acquired a superordinate status, bringing together other themes as subordinates. Polarisation involved looking for oppositional relationships between themes. Numeration involved considering the frequency with which themes emerged. With this information I produced a table of possible themes.

5. Moving to the next case

I analysed the first transcript in its entirety before moving on to the next one as suggested by Smith et al. (2009). In doing so, I did my best to bracket the ideas emerging from the analysis of the previous transcripts, in keeping with IPA's idiographic commitment.

6. Looking for patterns across cases

When all transcripts had been analysed as above, I combined theme clusters shared across all participants into a summary table. I paid close attention to the reoccurrence of themes across cases in order to enhance the validity of my findings, as suggested by Smith et al. (2009). I examined data systematically and came to the conclusion that a theme needed to be present in at least half of the accounts in order to be included in the final table of themes. I made an exception to this rule for some themes in group 4, as I thought it was particularly important and relevant to my research aims to include participants' experiences of coping with the voice, and this level of flexibility is allowed within IPA (Smith et al., 2009). Following the analysis of all transcripts I compiled a table of themes across all interviews including key quotes from the participants (Appendix 6).

Evaluation of the Research

There are different views regarding what is appropriate when assessing the validity and reliability of qualitative research. Madill et al. (2000) suggest that these criteria can be

problematic when applied to qualitative research. Particularly, if epistemological assumptions do not include the direct correspondence between research and external reality, as in the present study, it may be difficult to demonstrate validity and reliability. To address this discrepancy in assessment tools, Yardley (2000) proposes four broad principles for the evaluation of qualitative research.

The first criterion is to demonstrate “sensitivity to context” throughout the research process. This requires that research is grounded within relevant theory and literature and within the chosen research paradigm. Awareness of the socio-cultural setting of the research is also necessary. IPA as a methodology is particularly suited to demonstrating this criterion due to close engagement with the idiographic and the particular (Smith et al., 2009).

I have fulfilled this criterion in several ways. I thoroughly examined relevant literature and my research question is firmly rooted in its critical appraisal, as evidenced in the Introduction and Literature Review chapter. My methodological choices are justified with reference to the research aim, and their underlying epistemology and theoretical underpinnings are adequately explored earlier in this chapter. Throughout the research process I aimed to remain aware of the socio-cultural context in which the data was understood and analysed, including the role of my own knowledge, assumptions and life experience, as more explicitly described in the Reflexivity sections. I paid close attention to the participants’ meaning-making activities during interviews and whilst analysing the data. I also aimed to bracket my own knowledge and immerse myself in their lifeworld as much as possible. I aimed to give participants a voice and to present my interpretations as possible readings of the data. My findings were firmly rooted in the data, as evidenced by the rich and detailed verbatim extracts in the Analysis chapter.

The second criterion raised by Yardley (2000) is “commitment and rigour”. This refers to the thoroughness of the study in terms of competence in the research approach and analysis. With IPA, there is an expectation that commitment will be demonstrated in the degree of attentiveness to the participant during data collection and the care with which analysis is carried out (Smith et al., 2009). It also implies commitment and engagement with the research topic.

In meeting this criterion, I took a number of actions. I read widely about the topics of eating disorders, the critical inner voice and IPA, I also attended relevant lectures and seminars to learn more about the research process, eating disorders and relevant clinical approaches. I ensured that my data collection was thoroughly and ethically conducted, and that the number of participants was appropriate for the scope of this work. My experience of working in the field of eating disorders from a clinical perspective provided me with the necessary skills to sensitively interact with participants whilst producing rich and textured accounts during interviews. The

analysis was also conducted thoroughly and systematically, ensuring that themes emerged from the data and that participants' accounts were represented evenly across themes.

One criticism of this study related to "commitment and rigour" could be the level of homogeneity of the sample - it could be argued that the sample is not sufficiently homogenous and that this could have had an impact on the interpretation of the findings. I decided to include all eating disorders, all age groups, not differentiate across stages of recovery or therapeutic experiences. This decision was made consciously, on the basis of eating disorders sharing a core psychopathology (Fairburn, 2008; Trottier et al., 2015, Forrest et al., 2018) and wishing to undertake an exploratory study, which focuses on the possible commonalities of the inner voice across all eating disorders. In hindsight it may have been appropriate to further narrow down the sample in order to make it more homogenous. For example, including only participants at a later stage of recovery or who have engaged in treatment for a number of years, may have led to richer data, as it would have ensured that participants had the time and space to reflect on their experience of the critical inner voice. Similarly, I could have chosen to focus on one eating disorder only or selected participants that had engaged in a particular treatment approach. Alternatively, it can sometimes be helpful to divide the sample so that the phenomenon can be understood from more than one perspective (Smith et al. 2009). Given that this was an exploratory study on the critical inner voice across all eating disorders, a further division of the sample according to diagnosis or otherwise may not have suited the scope of the project.

Another criticism could be in relation to the interview schedule. In most interviews, I asked directly about the "critical inner voice" early in the process, which could have led participants to share more about the critical aspects of the voice as opposed to others. I could have instead begun by asking about the voice in general and how it related to participant's eating disorder. Keeping my questions more open may have left more space for participants to speak about their individual experiences and could have led to more authentic and richer accounts.

The third criterion is "transparency and coherence" and concerns the clarity with which the research process is described in the write-up of the study. It also requires that the research presents a coherent argument, with all aspects of the study linked in a logical way.

To this end, I provided a detailed account of the planning and implementation of the study whilst giving reasons for my choices, including outlining all aspects of the data collection process and analysis in the Methodology chapter. I aimed to conduct my research in accordance with the principles of IPA and hope that its roots in phenomenology and hermeneutics are apparent in the write-up of the study. I also ensured to address issues of reflexivity, including my personal

motivations for the research and any knowledge or experiences that could influence my analysis of the data.

Yardley's fourth criterion concerns "impact and importance". Research should aim to provide the reader with a new and useful way of understanding a topic which is relevant to the research field in question.

I believe that my research question elicited relevant and novel material which contributes to a better understanding of the critical inner voice experienced by individuals with eating disorders. I was struck by how much participants identified the experience of the critical inner voice as a key feature of their eating disorder and by their rich and detailed accounts of how it manifests throughout illness and recovery. I hope this research provides new insights into the phenomenon of the critical inner voice and eating disorders that may lead to further theoretical and clinical developments in the field of counselling psychology and beyond. Further details on the relevance and specific contributions of this study can be found in the Introduction and Discussion chapters.

I will now share my reflections in relation to the research topic and process.

2.4. Reflexivity

IPA acknowledges that research is a dynamic process which involves the participant and the researcher working together to unravel meaning (Smith et al. 2009). The research process should therefore involve reflection and self-awareness on the part of the researcher so that the study can be transparent and informative. My approach to reflexivity was primarily influenced by Finlay (2002), who stipulates that qualitative research entails a constant examination of personal and professional influences on the research process. To this end, a reflexive diary was kept, so that I could note down any thoughts and feelings as they occurred. I recorded any personal reflections that may be related to the research topic and process, as well as my impressions of interviews after they occurred. I also used questions suggested by Langridge (2007) as a guide for my reflexive practice (Appendix 7). I will assess both personal and methodological reflexivity within this section.

Personal Reflexivity

Willig (2012) states that the researcher's personal experience, or lack of personal experience of the phenomenon under investigation, needs to be thought about as it will inevitably frame the

researcher's approach to the topic. My own understanding and experience of eating disorders and the critical inner voice may have led me to seek out elements in participants' experiences which reflected or confirmed what I already knew. This has been described as the "seduction of sameness" (Oguntokun, 1998). Where there is a risk of this happening, it is particularly important to bracket my own experience to some extent or at least be aware of what elements of the research process may be affected by it.

I worked in a specialist inpatient eating disorders service for young people for approximately 3 years, as a Healthcare Assistant and as a Trainee Counselling Psychologist. This experience allowed me to spend a substantial amount of time with individuals suffering from eating disorders, in a therapeutic capacity as well as more informally on the ward. I was particularly struck by the patients' high levels of self-criticism and how they often framed this experience as a voice or personified entity. This became particularly strong after meals, and post-meal reflections often included patients experiencing negative self-talk or a voice accusing them of being greedy, disgusting and weak. My academic and clinical knowledge of eating disorders is likely to have influenced the way I interacted with participants in terms of what I chose to say or not to say. However, given that the majority of my experience related to anorexia nervosa in adolescence, I may have been inclined to make assumptions based on this knowledge that may not apply to adults or those suffering from other eating disorders. For example, I may have had preconceptions about their willingness to engage in the interview process as I had experienced many anorexic adolescents finding it difficult to express their feelings and thoughts openly. Similarly, my knowledge and perceptions may have influenced the way I analysed data.

Prior to working with eating disorders, my interest in them stemmed from having had some difficulties relating to body image and eating behaviour myself as a young woman, which I believe were mostly resolved about ten years ago. Despite the fact that they were not severe and they did not require treatment, they led me to spend much time and effort negotiating my relationship with food and confidence in my own body image. I believe that having had this experience allowed me to work empathically with eating disordered clients and also shielded me from being personally affected by working in the field, as I know can often happen.

I have not experienced a critical inner voice, however I do experience self-criticism at times in the form of negative self-talk. This was highlighted in my personal therapy and it is something I have become more aware of during my training, especially through learning about third wave CBT approaches. I tend to have thoughts about myself being "weak" emotionally and physically and therefore not as capable, efficient or resilient as others. I have high expectations of myself and a tendency to make challenging choices in life, which can reinforce my feelings of inadequacy. Observing similar thoughts and behaviours in participants was emotional for me at

times but also allowed me to connect with their experiences more deeply and learn from them on a personal level. Producing this piece of research further challenged me to reflect on my own self-criticism. I found the analysis process and write up quite difficult and often found myself having thoughts like “I am never going to finish”, “my work is not good enough”, “I am taking longer than others because I am lazy”. Thinking about participants’ experiences compounded these thoughts and led me to question the way in which I talk to myself.

Throughout the research process, I did my best to expand my awareness of how my own material, assumptions and experience may have been implicated. I hoped that being aware of my own process would allow me to bracket my experiences as well as acknowledge where that was not possible.

Methodological Reflexivity

During the process of data collection and analysis, I reflected on how the method influenced the type of knowledge produced in this study, as well as on my experience of the research process. As this was the first time I carried out a qualitative study, I did not quite know what to expect, which was quite anxiety provoking at times and possibly led me to question myself and my skills excessively.

To some extent, I expected the interview process to be relatively straight forward for me, given my experience with eating disorders. It was actually quite difficult to put into practice, mostly because I was constantly drawn towards interacting with participants in a therapeutic way rather than as a researcher. It was also challenging to find the right balance between answering the research question and following up matters as they arose. I was particularly conscious of not allowing the content of previous interviews to dictate the type of questions I asked. As I carried out interviews, I became more comfortable with the process and my technique evolved. Some participants found it easier than others to talk at length about their experiences, so that the richest data was likely to come from the more talkative individuals and feature more heavily in the analysis (Finch & Mason, 1990). Another challenge, when interviewing and analysing the data, was to tell whether material was relevant to the phenomenon of the critical inner voice.

The interviews generated a wealth of rich material, which I am grateful for. It was however challenging to analyse the material and produce a coherent and meaningful set of themes which encompassed participants’ experiences. My initial notes and themes were so many that I had to rearrange them several times before my supervisor and I were satisfied with them. Selecting quotes was also difficult, participants described their experiences beautifully and my instinct

was to use many quotes and let them speak for themselves. I eventually was able to reduce the number of quotes whilst also making my analysis more interpretative, adding my own reflections and learning to trust that they were valuable.

I will now address my considerations regarding the ethical issues raised by this research.

2.5. Ethical Considerations

The ethics of the study were considered with reference to the guidelines of the British Psychological Society (BPS), the Health and Care Professionals Council (HCPC) and City University. City University ethical approval was gained prior to data collection (Appendix 8). The four general principles described in the British Psychological Society's Code of Ethics and Conduct were considered at every stage of the research – these are "Respect", "Competence", "Responsibility" and "Integrity".

As Kimmel (1988) advises, the study did not involve any deception and all participants were informed of the true nature of the study prior to taking part. Before gaining consent, all participants were briefed on what would be expected of them and, to ensure full transparency, participants had the opportunity to ask questions about any aspect of the study. Information on the aims, procedures and use of findings was provided to the participants (Appendix 4) and their consent was obtained before the interviews were conducted (Appendix 5). Participants had the right to withdraw from the research within a month of the interview date. Following the interview, participants were debriefed and given the opportunity to express their thoughts about the interview process and content. All data was stored confidentially, with consent forms separated from data files. All identifying variables were removed from transcripts and audio-recordings were immediately downloaded onto a computer protected by a password to ensure confidentiality. Participants were advised that any data shared with others in the research process or any quotes included in the published research would be anonymous. Although it was anticipated that the interview process would not cause harm to participants, it was a possibility that participants may have been vulnerable and could become distressed when talking about their lived experience. As a result, all attempts were made to ensure that potential distress caused by the interviews was addressed by the researcher following the interview. Where participants were referred by clinicians in private practice, the clinicians assessed their suitability for the study with a particular view to emotional vulnerability and risk. The clinicians were also available as support following the interviews, if necessary, as part of their ongoing therapeutic relationship with participants. All participants were also provided with debrief information (Appendix 9) which encouraged them to speak to the researcher after the interview should they

have any concerns about the information they disclosed. The debrief information also suggested seeking help from mental health professionals or GPs should participants feel distressed following the interview. It also included details of helplines they may call for support.

A further important consideration was to ensure I related to participants as a researcher and not as a counselling psychologist. This was not always easy given that the differences between research and therapy are sometimes unclear (Hart & Crawford-Wright, 1999). Both therapy and phenomenological research aim to understand the participant, explore and clarify their experiences and gain access to the inner world. Being accustomed to the therapeutic process, I sometimes found it difficult to differentiate my approach in an interview setting and interact with participants according to the research needs as opposed to their needs. I was particularly mindful of not establishing a therapeutic relationship with participants and to only discuss topics that they were willing to share.

While the planning and implementation of research involved careful consideration of ethical principles, I was also aware of ethical issues as I completed the write-up of my study. During transcription and analysis I attempted to provide an account which respected participants' experiences and remained grounded in the data. I spent considerable time reflecting on the data and selecting the most significant excerpts in which participants' meaning-making became apparent. I kept in mind issues raised by Yardley (2000) regarding the transparency of my account and my involvement as a researcher. I also felt there was an ethical need for my research to be discussed with others to ensure verification (Kvale & Brinkman, 2009). I was aware that my data might be interpreted in different ways and I hoped that other perspectives would enhance and confirm my analysis so I presented my findings to two colleagues at various stages of the analysis process. Their feedback was helpful in ensuring that my themes were coherent, meaningful and grounded in the data.

Chapter 3: Analysis

3.1. Introduction

This chapter outlines the groups of themes derived from the interpretative phenomenological analysis of the nine participants' transcripts. The presented themes aim to provide a rich and detailed insight into participants' lived experience of the phenomenon of the critical inner voice in individuals with eating disorders. Not all themes are mutually exclusive but rather they can be permeable and related to each other.

The analysis of the transcripts was an interesting and immersive process. It yielded a wealth of information and insight into participants' experiences and it was difficult to find the most appropriate and meaningful way to represent their views. I hope to balance conveying participants' accounts in a holistic way with portraying the nuances of their individual experiences. For each theme I will select illustrative extracts of participants' words with the intention of best illustrating their views and combining my interpretation of the accounts of their lived experience. In this way I aim to fulfil the objective of IPA – creating a multi-layered exploration of meaning or “double hermeneutic” (Smith & Osborn, 2003).

I have structured the theme groups approximately in chronological order, starting from the origins of the voice to recovery. This highlights the pervasive nature of the voice and how it has accompanied participants throughout their lives. Themes also aim to build on one another, from broader to more specific, creating an increasingly rich picture of the experience of the critical inner voice. I begin with themes that are relevant to how the voice came into existence and how it evolved through illness and recovery (Group 1), moving onto themes relating to the content and everyday experience of the voice (Groups 2 and 3). I conclude by focusing on therapeutic experiences and managing the voice (Group 4).

The first group of themes sets the scene by outlining “A Lifetime with the Voice”. Participants share their thoughts around how the voice may have come into existence – a combination of parental influences, personality traits and early experiences. They also describe how the voice developed over time through different stages of illness and recovery.

The second group of themes concerns “The Voice in Action”. Participants speak of the central role the voice plays in their eating disorders, as a facilitator and maintainer of symptoms. The voice keeps a tight control on participants by criticising them and giving behavioural instructions.

Participants also speak of the voice's pervasive nature, affecting all aspects of life, and of its function as a motivator.

The third group of themes aims to convey what it is like to be "Living with the Voice". Participants describe how they experience the voice from a cognitive and relational perspective. They specifically describe the circular and relentless nature of the voice as well as its pervasive social impact, which fosters isolation.

The fourth group of themes focuses on "Coping with the Voice". Participants reflect on their experiences of addressing the voice in therapy and describe specific techniques they found helpful in managing their critical inner voice.

3.2. Groups of Themes

1. A Lifetime of the Voice
 - A. Birthing the Voice
 - B. Developing the Voice
2. The Voice in Action
 - A. The Voice is my Eating Disorder
 - I. "You are Greedy, Lazy and Fat"
 - II. "You don't Deserve to Eat or Rest"
 - B. The Voice Controls my Life
 - C. The Voice Motivates Me
3. Living with the Voice
 - A. A Constant Internal Struggle with a Dark Part of Me
 - B. A Relentless Vicious Cycle
 - C. Suspicion and Isolation
4. Coping with the Voice
 - A. The Voice in Therapy
 - B. Challenging the Voice
 - C. Distancing the Voice
 - D. Soothing the Voice

3.2.1. Theme Group 1: A Lifetime of the Voice

This group of themes captures the participants' descriptions of how the voice evolved over time, from its origins to the present day. The first theme encompasses participants' accounts of how the voice may have come into existence, as a combination of parental influences, personality traits and early experiences. The second theme outlines how the voice evolved from the time participants first became aware of it, through different stages of illness and recovery.

The wording of the theme names does not imply that participants actively or intentionally birthed and developed the voice. The theme titles are meant to give a sense of the voice being somewhat independent from participants, with a life of its own.

A. Birthing the Voice

This theme sets the scene by outlining participants' accounts of the possible origins of their critical inner voice. They make reference to factors relating to nature and nurture. Approximately half of the participants believe that their parents and family environment influenced the development of their critical voice, either because they experienced criticism from others or because their parents were critical towards themselves and therefore modelled a self-critical way of thinking. Two of these participants also believe that their own perfectionistic tendencies contributed to the development of the critical voice. An additional two participants only speak of the critical voice being a result of their personality.

Brenda speaks of her father having high expectations of her academically. In addition, she was naturally a perfectionist and very driven with learning so she would try to get his approval and became self-critical at a young age as a result.

My dad would always [say] you didn't want to get a C because [...] a C wouldn't be acceptable, and I can remember when I got my GCSE results back and I had a B in maths, it was the only B I got [...] and it was the first grade he noticed out of every other grade which was an A, so I've always been very much trying to [...] live up to what he wanted, I think, in turn it made me quite self-critical because I was naturally a perfectionist. When I was a small child [...] I always wanted to do more reading [...] I always wanted to learn and keep pushing whereas my middle sister just wanted to play all the time. So I think it was very much ingrained and then how my dad brought us up exacerbated it. (Brenda: 50-67)

Brenda's father noticed her lower grades first, almost taking her As for granted and possibly leading her to believe that getting As was normal and anything else was substandard. Brenda describes being a "people-pleaser" (Brenda: 304) and therefore always striving to get his approval as well as others'. It seems likely that growing up with such values and personality would cause Brenda to have high standards and be critical of herself academically and generally. She compares herself to her sisters, who were raised in the same environment but reacted in

different ways. She thinks being a people-pleaser and being “the most controlling and the most perfectionist out of all three of us” (Brenda: 318-319), combined with their upbringing, caused her to be more self-critical than her sisters.

Brenda recalls her father encouraging her to think ahead in terms of her academic and career plans, to the point where “I had my [...] ten-year plan by the time I was thirteen years old” (Brenda: 48). We will see in later themes that her critical and controlling voice makes it difficult to be spontaneous, she always needs to have short and long-term plans, and finds it difficult to relax unless she has scheduled it. This seems a reflection of behaviours that her father may have encouraged.

Clara also considers herself a perfectionist and she believes she inherited this trait from her father as well as learning from his behaviour.

I know that my dad has got [...] a very critical [voice], he probably has it worse than me in some ways, for example, he went to art college [...] but he won't draw or do anything artistic now because he knows he isn't as good as he used to be and he's got this crippling perfectionism and he'll really beat himself up...he's in his sixties now and he's still cycling and still expecting to beat his personal best record even though he's getting older and he will get angry at himself if he doesn't and so I know that he has that same thought pattern. He's much more obsessive than I am as well so I guess it's the nature nurture thing. (Clara: 681-693)

Clara has observed her father being very critical towards himself if he does not meet his own unrealistic expectations. She thinks that he also has a strong critical voice, and “crippling perfectionism”. It seems likely that Clara’s voice has developed partly as a result of growing up with her father, as well as their genetic similarities.

Clara recalls a particular phrase that her father used to say which she took very seriously as a child, but now realises it was probably a harmful attitude to adopt: “if a job’s worth doing it’s worth doing perfectly” (Clara: 701). During the interview, she hesitated to remember this phrase, which was a pleasant surprise to her. This may suggest the strong impact these words had on her but also indicates that she has been able to separate herself from this influence. She also reflects on how she would never say those words to a child, as they would stop them from experimenting and learning. Clara is a teacher, which has probably given her further insight into child development and she is able to apply this knowledge to her own childhood experiences.

Clara also recalls her own tendency to think in a way that was particularly rigid as a child. She would create rules about what was right and wrong and if she did something wrong, she would “feel ashamed, like I’d done something really bad [and] got told off, even if I hadn’t actually” (Clara: 33-34). This way of thinking may have also paved the way for her critical inner voice and the feelings of shame associated with it.

Diana grew up with an abusive mother and her critical voice is a reflection of the things her mother used to say to her as a child, so much so that it is difficult to “disentangle whether that voice is my own or my mother’s” (Diana: 27-28). Diana believes her critical voice developed because of the way her mother treated her.

It’s my voice but it’s been instilled from my mother’s values from when we were growing up, she used to say certain things all the time [...] and that is what is in my head... “you’re not good enough for that, you’re failing at this, you’re giving up your job, you’re a failure, you’re going to lose money, you’re lazy, you shouldn’t eat, you don’t deserve to be...” (Diana: 54-61)

It seems that, despite no longer having contact with her mother, Diana clearly recalls her words, in terms of what she would say in the past but also what she imagines she would say at present, like the comment about giving up her job. Perhaps Diana’s mother, the eating disorder, and Diana’s own thoughts have become entangled and given rise to her critical inner voice. Diana was not fully aware that her mother’s behaviour was abusive until adulthood. Her mother also loved her and “made me feel special” (Diana: 312) so that love and abuse became associated in Diana’s mind. Similarly, her critical voice also feels simultaneously like a companion and abuser.

Fiona was raised to believe that it was important to excel and be successful, that it was “essential to becoming a good person that would be loved and respected by people” (Fiona: 481-482).

I got this sense that [I had] so much potential, like putting me into music really young and always getting good grades and all the extracurricular activities, feeling like that’s what got me love, doing well at all these different things. And so if I continued doing well at everything, I would keep having love, but when I realised that I wasn’t always going to be this person who excelled at everything, a destructive side came out in me that wanted to rebel against the idea that I had to be good all the time and please everyone else, so that’s where the self-harm came in, and the drugs and of course the eating disorder [...] it was my act of saying “I don’t have to love myself, you can’t make me be that person that you want me to be”. (Fiona: 487-501)

As she got older she realised that it was impossible to always excel and please others and she rebelled against her family’s expectations. At the same time, she probably internalised such expectations and therefore punished herself by becoming self-critical and self-destructive.

Fiona also observed her mother being very critical of herself from a young age, which deeply affected her.

I talk to myself the way my mother talks to herself. And even though the voice is coming from me, I think a lot of the things I say to myself are things I’ve heard her say to herself, her very apparent lack of self-acceptance I think contributed to mine and feeling like “why should I accept myself?” because the female role model in my life doesn’t. (Fiona: 743-751)

She found it surprising that her mother was so dissatisfied with herself, particularly regarding her shape and weight. Fiona’s critical voice echoes some of the criticism that her mother

directed at herself. Fiona believes that her mother modelled a lack of self-acceptance, making it difficult for her to accept herself, and contributing to the development of her critical voice.

Alice and Holly also speak about being self-critical and perfectionistic since childhood.

I'm acutely self-conscious since childhood and it tends to be more critical than positive [...] I think for as long as I can remember I've kind of been aware of [...] constantly observing [myself] and having an image of [myself] and sometimes I just remember that being a bit humorous like people would laugh if I looked silly, I think some of it was because of comments that I had, [...] some teasing. (Alice: 37-55)

Alice recalls being particularly self-conscious, observing and criticising herself, often thinking she looked silly, "cartoonish" (Alice: 326) and "larger than life" (Alice: 69). She almost describes it as an out of body experience, a slightly dissociative state. She also had the constant feeling that she would not be taken seriously by others. This was linked to some bullying but also perhaps part of her personality and anxious nature. These early experiences are likely to have contributed to the development of her critical voice.

Two participants, Erica and Iris, did not mention about their early experiences contributing to their critical voice. Erica did not speak about her upbringing at all, she recalls the voice starting from puberty and being more linked to her social environment outside of her family. Iris also did not mention her early experiences as contributing to her critical voice, she speaks of her family fondly and cannot think of anything they may have done to lead her to be self-critical. She also links the start of her critical voice to her social environment, and a particular incident at school when a boy at school called her "fat". This event triggered her eating disorder along with the critical voice.

This theme encompasses participants' early experiences which may have contributed to the birth of their critical inner voice. They recall having perfectionistic tendencies since childhood, which were often compounded by parents' expectations of success and achievement or by abusive dynamics where love and criticism became intertwined. Some parents also modelled self-critical behaviour. It seems that these experiences had a strong impact on participants' attitudes towards themselves, which set the foundation for the development of their critical inner voice.

B. Developing the Voice

This theme gives a chronological perspective on the critical inner voice, describing its development from the time participants first became aware of it. It also encompasses how the voice relates to the development of their eating disorder and how it changed through illness and recovery. Nearly all participants speak of being aware of having a critical inner voice before

developing their eating disorder or at the same time, typically around puberty. The voice then evolved in different ways for each participant. For some participants the critical voice began to focus on general topics such as performance or likeability and then shifted to focusing on eating disorder related topics, for others it was the other way around. Participants speak of dealing with the critical voice as being the hardest part of recovery, lingering after eating disorder symptoms improve.

Fiona describes the voice as being present before her eating difficulties, around puberty.

[The voice] was definitely there before the eating disorder. I remember around 12 or 13 was when I started having that voice and at the time I didn't think it was an inner critic, I just thought it was something telling me how I could be better or what I could fix. I remember I used to go from head to toe, thinking about all the ways my body could be like a little bit better, and each body part what would make it the best ... I didn't know that was a negative thing, maybe at the time I thought that's how you get better. (Fiona: 171-182)

She did not initially experience the voice as negative, but rather as a way to improve herself. She recalls the voice focusing on her physical appearance, scanning each body part and commenting on how it could be improved. Perhaps the voice initially came from a place of curiosity rather than negative judgment. I wonder whether this is quite a common experience in adolescence as we deal with our changing bodies and develop our identities. It seems however that for Fiona it evolved into a much more destructive process.

Erica also describes becoming aware of her critical voice in early puberty, before she developed an eating disorder. The voice was initially focused on social comparison, generally making comments about her looks and not being liked by others. Once again, social comparison is a common focus for adolescents forming their identity, but for Erica it evolved into a strong critical voice as well. She began developing eating difficulties around the age of 15, but it seems that her critical voice had already laid the ground for them.

I think [the voice] definitely does link with my eating difficulties but I think it also links to other stuff... quite often around the feeling of [not being] good enough so in the past it would have been things like "nobody likes you" or "I'm stupid" which I think still carried on but then since I developed eating difficulties it's probably the majority focussed on [being fat] or it interlinks so it would be something like "oh people don't like you because you're fat". (Erica: 25-36)

Once her eating difficulties began, the voice became more focused on her weight and shape but also continued to criticise her overall. She describes the voice as generally focusing on not being "good enough" and linking a variety of different criticisms to being "fat".

Holly recalls her earliest experiences of the critical voice dating back to her teenage years during her exams.

I think [the critical voice] took hold when I was a teenager, I was doing my exams and feeling that I wasn't going to pass, that I wasn't working hard enough and no matter how much I did [...] that was never good enough. It was always "you could have done more", "what if you'd worked harder" ... I think that's also the age when I started to become unwell as well. (Holly: 179-189)

The voice initially focused on revision, it suggested that whatever she did was "never good enough". We will see in later themes that this is a typical presentation of the voice, whether it relates to eating behaviour or not. Holly seems to describe it as a coincidence that this is also when she became unwell but I suspect that there is probably a link between the two occurrences.

Alice had a different experience – her critical voice developed alongside her decision "to cut back on my eating" (Alice: 117), despite always having been self-critical. The voice criticised her for being "greedy and lazy" (Alice: 145). The voice then spread to other areas of life, focusing on similar topics.

It then began to spread to other areas like not working hard enough, being lazy, not exercising enough and not being brave enough, not pushing myself hard enough. (Alice: 142-145)

Brenda also spoke of her critical voice starting in relation to her eating difficulties and evolving over time. Initially it was making suggestions on how to think and behave, and felt somewhat helpful, and then as her eating disorder developed "it became stronger than me" (Brenda: 162).

It felt like someone was telling me to think or react in certain ways to things, it felt much more like "well, you've got to do this now because you've just done that" rather than me going "oh I feel like this, I.. I should do this or maybe I should do that". (Brenda: 166- 170)

It seems that, over time, Brenda lost control and the voice took over. It began telling her what to do rather than just contributing to her thought process, and impacted all areas of her life. She has now recovered from her eating disordered behaviours but the voice "is the one bit that is still hanging around" (Brenda: 27).

I'm not in the space where I feel like my critical voice completely informs everything I do any more but it certainly plays a major role in my life and I think if I wrote down every time that I had a critical thought from my voice it probably would be quite a few during the day. I would consider myself recovered really from the behaviours, the mind-set however is much harder to get rid of and I haven't known not having a critical voice. (Brenda: 195-204)

It does not control her life to the same extent but it is still present on a daily basis. Brenda thinks that it is much harder to overcome her critical voice than it is to change her behaviours. This view seems to be shared by the majority of participants, who struggle with their critical inner voice long after recovery. This has important implications for treatment, as will be highlighted in later themes.

Grace and Iris agree that the voice lingers long after recovery from eating disordered behaviours, even though the eating disorder and the voice are linked.

Coming through recovery is harder because you're trying to fight back against something that is quite a loud thing that you don't really know how to get rid of because you're doing everything right to keep yourself healthy but it still wants to control you... and that's the hardest bit. (Iris: 34-38)

"Fighting back" against the voice was the hardest part of recovery for Iris. Healthy behaviours seem to make the voice louder as it attempts to maintain control. After recovery the voice becomes easier to manage and "doesn't have the same controlling aspects it used to" (Iris: 10) but remains present.

This theme helps to frame participants' experiences of the critical inner voice over time. It appears that most participants first became aware of their critical inner voice around puberty, in close proximity to the development of their eating disorder. For most participants, the voice creeps in slowly, initially feeling somewhat helpful but then becoming negative and controlling. The content of the voice is both related to eating disorder symptoms and life in general, and developed in a different sequence for each participant. A distinctive feature of the voice over time is that it fades but does not seem to go away after recovery. The following group of themes highlights just how much the voice affects all areas of life.

3.2.2. Theme Group 2: The Voice in Action

This group of themes aims to describe what the voice does in detail. It encompasses the different ways in which the voice manifests itself, including the topics it focuses on and functions it serves. Participants speak of the voice and their eating disorder being one and the same - the voice drives the eating disorder by criticising them and telling them what to do. They also mention how it impacts their life in general, aside from their eating disorder. Most accounts of the voice are framed in a negative way, with the exception of the last theme, in which the voice displays some positive characteristics as a motivating force in participants' lives.

A. The Voice is my Eating Disorder

This theme captures the content of the voice which directly relates to participants' eating disorders. Iris and other participants hold that the voice is what drives their eating disorder – symptoms are a consequence of having a critical and controlling inner voice. Iris expresses frustration that many people mistake anorexia for a physical or behavioural illness, when these are just symptoms caused by the voice.

Anorexia isn't just a physical illness [...] it is very much half a mental battle as well, people don't realise that actually it's not just [physical] and the eating is just a symptom... It's almost like that's the part that is the consequence of having this inner voice that is very controlling. (Iris: 400-409)

All participants describe the critical voice as being an integral part of their eating disorder – it criticises them in relation to their shape and weight and encourages them to engage in eating disordered behaviours such as restriction and excessive exercise. Participants differentiate between criticism and behavioural instructions coming from the voice, hence this theme will be presented in two parts.

I. “You are Greedy, Lazy and Fat”

Participants describe similar types of criticism from the voice. What the voice says appears to encourage eating disordered behaviour and maintain low self-esteem.

The [criticism of my] appearance is the most acute. (Fiona: 338-339)

[The voice calls me] “greedy” or says stuff like “no-one likes you”, yeah mainly centred around weight and stuff and being greedy. (Erica: 122-124)

I would hear a voice criticising me for being greedy and being lazy and that kind of thing. (Alice: 118-120)

The voice criticises participants' appearance, it accuses them of being “fat” and “disgusting”, it may also pick on other features like their skin or hair. Being “greedy” is also a common criticism, which indirectly encourages restriction. On the other hand, being called “lazy” encourages excessive exercise and activity. Social likeability also comes into play, with the voice commenting on what others may think of the participants.

Erica mentions that the voice may criticise her in a particular situation and then generalise.

If I tried on one thing and it was too small I'd be like “well you're too fat for any clothes” or if I think I look fat in one thing then it will be like “you're really fat and everything looks horrible on you” so it generalises beyond the specific situation. (Erica: 333-337)

The voice appears to take the opportunity to put her down beyond the present situation, by concluding that she is “too fat for any clothes”, which is clearly false. Similarly, the voice will compare her to other people who are thinner or eat less than her in a particular setting and say that “everyone is thinner than you are” (Erica: 352). The voice will filter information by ignoring people who are not thinner or eating less, fabricating an unfavourable comparison for Erica. Interestingly, Erica uses CBT terminology when describing these features of the voice. This may indicate that she has reflected on the voice in therapy, contributing to her awareness and understanding of the voice.

Fiona and other participants also say that the voice criticises them for being unwell and not working hard enough towards recovery.

Now I'm at the point where things aren't going well [...] that's where that inner critic comes. I'm like "how did I let this happen again? After all that hard work in recovery, how can I let these behaviours come back [...] and control my life?". (Fiona: 150-157)

This seems like a paradox given that the voice also maintains their eating disorders. It could, however, indirectly influence participants to abandon recovery by blaming them and making them feel powerless. Framing a relapse as part of the recovery process, on the other hand, would be more helpful.

Iris mentions that the type of criticism coming from the voice varies according to where she is in terms of recovery.

When I was controlling what I was eating quite heavily with anorexia it would talk more about food but then in recovery it picks on the way I look and my body image. (Iris: 106-109)

When more unwell, the voice tends to criticise her eating habits whereas during recovery it criticises her body more. It appears that the voice shifts form depending on what would be more effective or appropriate at the time – regardless of the situation it will find something negative to say. This seems to be a key characteristic of the voice and will be explored further in later themes.

II. "You Don't Deserve to Eat or Rest"

Participants mention that the voice gives them instructions to engage in eating disordered behaviours like restriction and excessive exercise. For most participants these instructions are framed with reference to the concept of "deserving". The voice often uses this to justify the requests it makes, especially around denying themselves food or pleasure of any kind. The voice also leverages the criticisms described above to control participants' behaviours.

Diana's voice often accuses her of being lazy and pushes her to exercise more. The below example gives a sense of how persistent the voice can be.

"You've been lazy today, if you didn't go for a run today you've got to go tomorrow and you've got to double your run or you've got to feel like you really push it". (Diana: 177-179)

Diana's critical voice appears to want to punish her for being lazy. She must not only run tomorrow, but double her run and run faster. It also motivates her to restrict by promising that

she will look good and convincing her that “I don’t need to eat, I don’t deserve to eat” (Diana: 372)

Similarly, Fiona’s critical voice will encourage her to restrict as a form of punishment when she feels bad about herself.

I start restricting when I start feeling bad about myself because I think I shouldn’t be able to have these foods that are just pleasure foods if it isn’t healthy, like cake or cookies or anything... anything like that, that doesn’t have nutritional value. (Fiona: 245-249)

She feels she does not “deserve” to eat for pleasure. She acknowledges that this is rather harsh but nevertheless complies, it seems the voice’s instructions are very difficult to ignore. Alice’s voice similarly comments on her choices when she goes food shopping. It stops her from buying things by accusing her of being greedy or not needing them, and she ends up walking out with hardly anything.

Grace’s voice will also make links between her life in general and “deserving” to eat, if anything is not going well, the voice will use this as a reason to try to convince her that she does not deserve to eat.

If I’m stressed about work or friends or whatever it will use that as an excuse to tell me I’m a bad person and I shouldn’t eat like “your friend fell out with you, you’re a bad person, you shouldn’t eat”. (Grace: 100-104)

It will also encourage her to restrict at any opportunity. For example, skipping a meal is presented by the voice as a good reason to skip another, creating a snowball effect. Despite the reasons given by the voice being quite unreasonable, participants seem to feel compelled to follow its instructions.

Holly’s voice also often speaks of not “deserving” to eat, but also not “deserving” to rest.

In terms of eating-related things it’s often about thinking that I don’t deserve something, that I don’t need something perhaps that I might like. It does make it a lot harder to rest as well and just generally saps enjoyment out of everyday activities. (Holly: 114-148)

The voice makes it difficult to enjoy food and life in general because of having such a strong focus on being productive and earning anything enjoyable by meeting unrealistic standards.

B. The Voice Controls my Life

All but one participant also mention that the voice criticises them and controls them in ways that are not directly related to their eating disorder. They experience criticism relating to all aspects of life, from work, to interpersonal relationships and general performance. The voice

also encourages them to be productive and have high standards in all endeavours. Conversely, others experience the voice as putting them down to the extent where they believe they are not capable of anything, lowering their self-esteem and paralysing them.

The concept of not “deserving” or not being worthy carries over from the above theme and becomes applied to more general areas of life. It makes it difficult for participants to be kind or generous to themselves.

[The voice] was a lot around feeling like I shouldn't spend money on myself and I should do without things a lot. [The voice] is like “why should you have nice things? what gives you the right to think that you should have that?”. (Alice: 509-513)

Alice's inner voice is often focused on saving money – she does not deserve nice things but also sometimes denies herself basic necessities, like heating or public transport. The voice appears to be questioning all of Alice's decisions, checking whether she truly deserves things and making her feel like she has to work hard or meet unrealistic standards before she can allow herself to buy anything.

Participants describe the voice as “criticising literally everything I did” (Alice: 128). No matter what they do it is “never good enough” (Erica: 490). It seems the voice will take the opportunity to criticise anything, even things that would not normally invite criticism. For example, the voice takes the opportunity to conclude that Grace is stupid, simply because she bumped into someone on the tube, something most of us would not even notice. The constant presence of the critical voice must be difficult to live with, I imagine it to be extremely draining and invalidating.

Holly's voice also often compares her to others, to highlight that she could be doing better.

If it's an activity that I'm doing it will often be like I'm not doing it well enough, that other people could do it a lot better than me, or I shouldn't have made that decision and that's a wrong decision. (Holly: 21-24)

It is unclear whether the voice refers to real or imagined others when comparing, but it seems effective in making Holly feel negative about herself in any case. It also questions every decision Holly takes, making it difficult to feel confident about her choices.

The voice also tends to discount any positives and focuses on the negatives, giving them more importance.

There's always something that's like, if I did well in one aspect, “you did really bad in all these other things” so I find it hard to focus on any positive thoughts. (Erica: 380-383)

Erica describes an internal dialogue whereby she will try to highlight positive achievements to herself but the voice will find something negative to comment on and draw her attention to it. Fiona has a similar experience.

The critic just keeps reminding me of my worth all the time [...] like how many good things I did this week, how many bad things. (Fiona: 557-561)

Fiona's inner critic keeps score of how many good or bad things she has done and draws conclusions based on this, her worth being dependent on doing good things. It seems difficult for participants to see themselves as having any value unless they fulfil certain criteria, which tend to be unrealistic. She mentions elsewhere that pleasing others, for example, has always been a way to measure her "goodness" and if she cannot please others she will feel like she is to blame. The concept of "unconditional positive regard" (Rogers, 1951) comes to mind, it seems that participants are unable to show this towards themselves. Their self-structure is instead characterized by specific/oppressive conditions of worth (Rogers, 1951).

The voice makes it particularly difficult to be confident at work. Several participants describe working extremely hard for fear of not being good enough. Despite promotions and praise, it is difficult to feel that they are valuable employees.

[The voice] can be a like "you're doing everything wrong" or "they think you're not good at it" or getting to know people on the job as well, "they don't like me". (Erica: 428-433)

Erica has just started a new job and she is finding it difficult to settle in because of the constant questioning by her inner critic relating to her performance as well as her likeability.

In a different field, Fiona also finds it difficult to feel confident about her art.

I'm an artist, but it keeps me from sharing my art with anyone because I'm scared of rejection, of feeling like what I create isn't of value, I think, "maybe I could put it on Instagram", but [...] inside me I'm hearing "no, that's not OK, it's not safe to do that" because I don't think I'm going to get the feedback I want. (Fiona: 633-64)

Her art work is very personal to her and she worries about sharing it in a public domain for fear it will not be well received. This would feel like a professional and personal rejection, linking to her sense of worth or value overall. Her inner critic holds her back from doing so because it is not "safe". This has a protective rather than critical quality to it, but it remains rooted in the fear that her work may not be "good enough".

For several participants, the voice also focuses on productivity and performance, it encourages them to constantly be active and to do everything well in their professional and personal lives. The consequence of not following its instructions tends to be intense anxiety.

I can't just sit and be, I have to be productive in life, organising finances, going to the shops, [...] cleaning, practical tangible things. [If I do nothing] the voice will get louder and I get chest tightness and find it hard to breathe so that causes the anxiety. (Diana: 158-165)

Diana's critical voice pushes her to be productive in everyday activities, if she stops following its instructions she will get symptoms of anxiety or panic. This maintains the voice's tight control on her and stops her from taking time to rest or reflect. The voice also encourages her to "be successful, [...] get to the top at anything [...] and not stop" (Diana: 15-116). It seems to be difficult to ever satisfy the voice, it always pushes for more. Diana realises that this attitude is too extreme and therefore harmful but she finds it difficult to behave otherwise.

Brenda also has a strong need to be productive and organised, encouraged by the voice.

I am very critical of how organised I am. When we got our moving date, the first thing I did was schedule every single thing that we needed to do and put it in the calendar so that I had a plan and I could feel calm and when there was nothing left to do and I felt like I wasn't doing enough again, I had to put more things in and start doing more stuff because my inner voice was going "you can't just be doing nothing, [...] you can't just come home from work and stop for ten minutes, you've got to go straight into doing what you need to do." (Brenda: 107-199)

She has a tendency to schedule all activities to ensure she is productive, this makes her feel calm and in control as long as there is always more to do. When she runs out of things to do, she becomes anxious and unsettled again. Her voice tells her "you can't just be doing nothing" and makes her feel guilty. Brenda knows this way of being is not healthy but she finds it very hard to change.

For some participants, the voice can be so controlling that it becomes paralysing. By having such exacting standards, it causes an extreme lack of confidence so that participants hold back from exploring opportunities like new positions, projects or degrees. Holly describes this happening particularly when she finds something difficult.

If I don't feel that I'm achieving something or I'm not good at something and it's just lots of effort [...] then the self-critical voice is harsh, rather than telling me to keep going, it's just "you're not good at this, you need to give it up", "you're never going to be good enough". (Holly: 116-112)

There seems to come a point where the voice stops telling her to keep going and working harder and instead tells her to give up. Holly describes the voice as speaking with a tone of certainty, so that she takes what it says as a fact and complies.

Grace and Fiona also describe the voice as mostly invalidating, Grace's voice comes in whenever "I do anything, it's telling me I can't do it" (Grace: 29-30). Fiona's voice also convinces her that she is not capable when she probably is, it says a lot of "you can't do that" (Fiona: 359).

This theme exemplifies the various ways in which the critical voice affects participants in their everyday lives, aside from their eating disorder. It criticises everything they do and reminds them of their worth by relating it to their actions. It particularly criticises them in a professional setting, making it difficult to take on new opportunities and projects. It also encourages productivity and performance excessively in their personal lives, making it difficult to relax and enjoy themselves. For some there also comes a point where the voice convinces them to give up, rather than work hard, and it becomes invalidating and paralysing.

C. The Voice Motivates Me

This theme presents the voice under a more positive light, as a motivating force which has enabled some participants to achieve more than they would have otherwise. Five participants describe a voice encouraging them and supporting them in their pursuits, which they find useful. It could be seen as a related positive side to the above aspect of the voice which pushes participants to work excessively hard. Although this theme is not as prevalent as others, I thought it important to present by contrast.

In some ways it's been a good thing because it's certainly pushed me to do things that I might not have done. (Alice: 214-216)

[The voice] also affects trying [...] really hard with uni work, so I guess it's a bit of a motivator in that way. (Erica: 167-170)

For Grace, the realisation that the voice may partly have a positive function came about as a result of reflecting on it during the interview.

I'd not really thought of it as a positive. I'd always thought of it as a negative part of my personality but then if it's [...] making me work and making me do better at certain things then maybe it is a good thing. (Grace: 325-329)

This shows that she is still in the process of giving meaning to her experience of the critical voice. The interview process can play a part in co-constructing meaning for participants and researcher (Smith et al., 2009).

Brenda also acknowledges that the voice has enabled her to do well in life.

I don't dislike it entirely. I think sometimes I'm a bit harsh on myself but I also know that I wouldn't have achieved what I've achieved in my life and I wouldn't have got the grades I've got, I wouldn't have done what I've done at uni or anything like that if I didn't have a little bit of that in me. I think to a certain extent most successful people will have that voice that gives them the motivation and determination to push themselves. It's just that mine [...] becomes a negative experience, rather than pushing me on to something positive, it pushes me down. (Brenda: 178-187)

She reflects that the voice has motivated her to achieve and that aspects of it have been helpful. She imagines that most successful people have a similar voice that gives them determination. Her own voice, however, can turn into a negative experience, from something that gives her positive encouragement to something that crushes her.

Holly further highlights the difference between the critical voice and motivating voice, and how she can tell them apart.

In some respects it does push me to do things that I otherwise wouldn't really want to do, so [...] having that voice means perhaps I'm more likely to do it, like "you can't give up, you need to keep trying" but I'm not sure that's necessarily the same self-critical voice, I think it's different. [...] I think deep down I know that for those things I don't want to do, I know there's a reason for it, I know that it's logical whereas if it's just being self-critical of myself, often I know it's not logical. I know that somebody else wouldn't say the same thing to me. (Holly: 55-72)

Her motivating voice encourages her to keep trying, causing her to achieve things that are right for her and "logical", whereas the critical voice is not logical. The motivating voice tells her things that other people may also reasonably say to her, unlike the critical voice.

This theme highlights a unique aspect of the voice which can be helpful. Perhaps this is part of the reason why it is so difficult to eliminate – in order to do so participants may also lose this valuable element of the voice.

3.2.3. Theme Group 3: Living with the Voice

The following themes convey what it is like to live with the voice on a daily basis. Firstly, participants describe the voice as they experience it from a cognitive and relational perspective, with participants' accounts varying from experiencing the voice as their own thought to an internal personified entity. We then focus on a particularly salient characteristic of the voice – its relentless and circular nature. Finally, we highlight the social impact of the voice – it keeps participants isolated and acts as a barrier to care and support.

A. A Constant Internal Struggle with a Dark Part of Me

This theme encompasses participants' accounts of how the voice is experienced from a cognitive and relational perspective. All but one participant describe the voice as a constant and automatic cognitive process. However, there is some variation as to how participants perceive the critical inner voice in relation to themselves. Some participants specifically make comments about how the voice compares to thoughts and perceive it as their own voice, others see it as coming from

a different side of themselves, yet others experience the voice as coming from an internal personified entity. The degree of distance between participants and their critical inner voice varies across as well as within participants' accounts.

Most participants speak of the voice as constant and pervasive in nature. It seems to always be present in the background, like an automatic commentary to their lives.

It's just hard to stop because it's so habitual. (Erica: 175-176)

I don't have much reason to criticise myself constantly but still I feel that there is a very automatic kind of consciousness of doing that [...] commentary that you hear going on. For example, [right now] I feel like I've been talking too much, I sound really young, I sound nervous, it just goes on... (Alice: 10-19)

Alice and Erica describe the voice as automatic and habitual. Erica mentions that she is not always aware of the voice "but if I tried to be conscious of it, it's actually really frequent and colours everything" (Erica: 440-443). Alice speaks of the voice as similar to criticising herself automatically and constantly, she is aware that there is often no reason to do so but the voice will make comments anyway. Interestingly, she mentions what the voice is saying during the interview process, which gives us an insight into her experience. Some of the comments seem related to her current behaviour, others are related to Alice's general beliefs about herself and her insecurities. The comments are in the first person, indicating that the voice is her own in this instance, she is effectively criticising herself.

Several participants compare the voice to thinking, for some it also evolves into an internal dialogue. Iris describes the voice as similar to thinking or daydreaming.

The voice is very much in my own head, it's almost like normal and internal thinking to me, so if I was ever daydreaming it would be like that. (Iris: 283-287)

She compares the voice to "normal thinking" but slightly less conscious. When one is daydreaming, they are often distracted, and it seems the voice also distracts her from being present in her life.

Clara describes how the voice evolved for her, from an involuntary thought to a more conscious internal monologue.

I think early on it was a thought but not my thought, but I was kind of aware I didn't really know why I had to do something or why I thought something. I think later on it developed a bit more like a voice but not an external one just like an internal sort of monologue going on. (Clara: 41-45)

To begin with, the voice felt like a thought but not her own, perhaps an intrusive thought that pushed her to behave or think in a certain way. It later developed more into an inner voice,

whereby she could have an internal monologue going on in her mind. Once again, the monologue would be in the first person indicating that Clara's inner voice is her own.

Brenda also says that her voice is similar to thinking. She further differentiates between talking to herself out loud and having an internal monologue.

[The voice manifests itself in] one of two ways. Mostly I talk to myself out loud quite a lot anyway. [I also] have an internal monologue going that I'm very conscious of, [...] sometimes I'll just sit there and I'll just be thinking constantly so it can be internal but I can externalise it by talking about it but I'm always aware, I make comments to myself all the time. (Brenda: 74-83)

The voice is the same, it simply can take two different forms. In both cases she is aware that she is talking to herself or about herself. On further reflection, it would be interesting to know whether there is any reason why the monologue or dialogue may be internal or external, or whether the experience or content is different between the two forms. Brenda's experience has a more relational quality when it is experienced like a dialogue with herself.

Grace also describes the voice as her own and experiences an internal process whereby she will have conversations with herself.

It's just my own voice, [...] sometimes I'll have conversations with it, like going backwards and forwards, but it's just me [...] Like today, I was off work and I was, like, well "maybe I shouldn't eat because I'm not doing anything and there's no reason for me to eat" but then I'm like "well I need to eat, everyone needs to eat". [...] It goes backwards and forwards. (Grace: 55-65)

She may, for example, reason with herself about what to eat. This can develop into an argument between the eating disordered side of her and her more rational side and can be rather exhausting.

Erica says that the voice is her own, not separate from herself, but with a different tone.

I guess it's just like my voice but probably quite shouty and angry, but I don't really see it as a different person or anything like that. (Erica: 130)

She identifies the voice as her own, as if she were criticising herself harshly, perhaps it is coming from a different part of herself. Similarly, Fiona experiences the voice as her own but coming from a different side of her, a mean side.

I think it's definitely my voice, but it's a different side of me... I feel like in my head there's not different voices, but they're coming from different parts of me and, that inner critic voice, it's a very nasty mean side, [...] as if I was a bad parent to myself, [...] the one who is punishing and won't let me experience good things. (Fiona: 539-546)

She compares this side of her to a critical parent, who does not praise her or encourage her to experience good things but rather judges her and punishes her. Fiona does not relate this to her actual parents' behaviour, unlike other participants.

At times participants can also experience the voice as more separate from themselves, but still internal. Diana clearly experiences it as her mother's voice. Diana's mother was abusive, controlling and critical and her inner voice displays the same qualities.

It's been difficult trying to disentangle whether that voice is almost my own or my mother's. (Diana: 26-28)

Alice imagines the voice as belonging to someone resilient, who has overcome difficulties in their life.

I imagine [the voice of] somebody who is confident and tough and maybe they have experienced problems in their life which they manage to be resilient and deal with, unlike me who hasn't really had any problems apart from the ones created entirely in her own mind, which makes me feel ashamed. (Alice: 488-493)

This image automatically makes her feel ashamed as she compares herself to them, which compounds the critical content of the voice. She sees herself as not having any problems, except the ones "created entirely in her own mind", unlike the imagined owner of the voice who has overcome real difficulties effectively. This description of Alice's experience is different from the above where she describes the voice as similar to her own self-critical thoughts. It is interesting to notice that the voice can take different forms for the same participant.

Clara, describes the voice as either sounding seductive or like a spoilt child. In this description, it sounds more like a separate internal entity, speaking in the second person.

It varies between sounding a bit like a spoilt child and then sometimes a bit seducing... [...] most of the time it does the sort of "but you know you want to", that sort of tone. It's only if I'm putting my foot down then it gets a bit like a spoilt child. (Clara: 148-158)

It tends to begin with a seductive tone but if she does not comply then it will change to sounding like a spoilt child. It's interesting to notice the interactive nature of the voice, and how it will adjust according to the participant's reaction.

Holly describes the voice as sounding like thoughts but also like a "murmur", rather than a clear voice.

I don't hear it as a voice, they're just thoughts [...] It's not like a different voice, it's just sort of a murmur that's often there. I visualise it as being like someone behind you all the time telling you to keep going and going and going [...] not like a person, just an image that I get sometimes. (Holly: 98-110)

She imagines someone behind her telling her to keep going softly but persistently. This image makes it sound like the voice is a personified entity speaking to her, but at the same time its content is a product of her own thinking.

I have noticed that throughout the interviews, most participants appear to use the words “voice” and “thoughts” interchangeably, however I wonder if their choice of words conveys a varying degree of distance between them and the phenomenon they are describing.

This theme encompasses participants’ descriptions of the voice from a cognitive and relational perspective. There is some variation within the theme but also many commonalities among participants. Participants describe a constant automatic commentary to their lives which colours everything, this commentary can take the form of a process similar to thinking, a monologue, a dialogue with a different part of themselves or sometimes a personified entity talking to them. The relational aspect of the critical inner voice appears to manifest as along a spectrum.

B. A Relentless Vicious Cycle

This theme describes a unique feature of the voice which emerges from participants’ accounts in a significant way. All participants describe the voice as relentless and circular in nature, so that complying with it may quieten it temporarily but eventually reinforces it, creating a vicious cycle.

Brenda talks about the relentless nature of the voice.

[When the voice comes in] it’s all you can think about until you’ve done something about it [...] It makes it very difficult to focus on anything else. (Brenda: 342-345)

It makes it difficult to focus on anything else until she does something to satisfy it, for example, exercise or do something productive.

Grace adds that the voice cannot be fully satisfied.

I don’t think it can be satisfied. If I don’t eat one meal it always wants more or if my weight has dropped a bit due to just life, it always wants it to be [lower] so it can’t ever really be satisfied. (Grace: 92-94)

Even if she complies with it on occasion, it will always want more - it demands more weight loss, skipping meals, more exercise. As a result, the eating disorder maintains its control.

Erica and Fiona further comment on the circular pattern that the voice creates.

I think it can impact my behaviour as well so if I’ve been thinking that “I’m really fat” then it can make me restrict more but then the restricting sort impacts the voice as well so it’s a bit of a loop. (Erica: 398-402)

According to Erica, the voice causes restriction but restriction also causes the voice to get stronger and more frequent, creating a “loop”.

Similarly, Fiona describes the critical voice as “feeding” her eating disorder.

If I’m having critical thoughts, it pushes me toward the disorder and the disorder is fed. If I’m having behaviours often, that in turn brings more [criticism]. (Fiona: 186-189)

Her critical thoughts bring eating disordered behaviours, which in turn cause more criticism, maintaining her eating disorder.

Iris further comments on how the voice and eating disorders interact to create a cycle of control.

It’s a bit of a lose, lose situation. [...] because you feel bad either way but one of the ways is actually a fine way to live and helping yourself and just enjoying eating and the other [way] is just controlling you but if you do give into it you don’t feel as bad, which is the entire controlling side of anorexia, which the more you listen to it the quieter it gets but the unhealthier you become in the end. (Iris: 95-102)

She highlights that whether you try to satisfy the voice or not, you will end up “losing”. If you satisfy it, by restricting for example, you will maintain the eating disorder and remain unwell, but if you do not satisfy it, you will feel extremely guilty. In her opinion, this is how anorexia maintains its control.

The voice also affects participants’ attitudes about recovery, creating a different kind of cycle.

I’ll end up getting really angry at myself and be like “I’m rubbish, I can’t even eat dinner with my friends”. It has become like the opposite thing where I almost want to be perfect at recovery so then I’ll beat myself up for not doing it properly, which is a bit of a vicious circle. (Clara: 622-626)

Clara applies her perfectionistic thinking to recovery, whereby she will criticise herself for not “doing it properly”. This can motivate her at times but when she feels she is not doing well it can also lead her to give up and relapse. This way of thinking ultimately feeds the same voice which maintains the eating disorder. A more accepting stance would probably be more effective to facilitate recovery.

Aside from maintaining eating disorder related thoughts and behaviours, the voice’s circular nature can also have a wider impact on participants’ lives.

Alice describes how the voice influenced her initial career choice.

I deliberately put myself into the most challenging environment I could, I got a place [studying music] and even though I was beginning to get performance anxiety I still went for it partly because that’s what I wanted to do but also this kind of self-fulfilling prophecy that I needed to prove that I was brave enough to put myself out there. (Alice: 162-168)

She challenged herself to study music, despite the detrimental effect it might have on her because of her anxiety. She thinks this decision was partly due to the need to prove to herself that she was capable, as a result of having a critical inner voice. She challenged herself to the point where she failed, creating a “self-fulfilling prophecy” that reinforced her self-critical beliefs.

Diana also speaks of the voice’s role in a professional context.

I think once you get into that cycle it gets worse. I had that bit of realisation about my work and I stopped working, I think that was a point where I maybe jumped out of that cycle. The work easily facilitates the voice just to keep ticking along in the background and everything just to keep going faster and faster and then you just can’t get out of it. (Diana: 180-192)

She thinks that her demanding work as a doctor and her critical and controlling inner voice became linked and created a cycle of perfectionism and excessive activity. The voice encouraged her to keep going, and her training always presented her with new challenges and goals so that the voice could easily continue “ticking along” in the background. Her recent decision to take time off work is an attempt to break that cycle.

This theme highlights a distinctive feature of the critical inner voice which plays an important role for all participants. The voice creates a relentless vicious cycle which maintains eating disordered thoughts and behaviours and sabotages recovery. The circular nature of the voice also impacts on other areas of life – participants have a tendency to challenge themselves excessively, sometimes leading to a self-fulfilling prophecy and failure, which reinforces the critical inner voice.

C. Suspicion and Isolation

Nearly all participants comment on the impact of the voice on their social interactions and relationships. It seems particularly relevant to explore this aspect of living with the voice, since it highlights the isolation which often maintains eating disorders and prevents individuals from seeking support.

Participants are generally concerned with how others perceive them, fearing that they will not be liked or that others will think negatively of them. Holly worries that “other people will be critical towards me” (Holly: 253-254) even when she is not feeling critical towards herself. Clara also says that the voice is “linked to what people think of me socially” (Clara: 632-633). The voice will leverage these concerns to plant self-doubt with more credibility and create a wariness of others.

The critical voice has a tendency to encourage a negative interpretation of others' words. Clara gives an example of how the voice interferes when she is trying to reach out to others.

If I say "do you want to go to the cinema tomorrow?" and someone says "yes" then that part of my brain will be saying "they're just saying yes because they feel sorry for you, they don't really like you" and "you're just putting them out, they're annoyed now that you've told them to come to the cinema with you". (Clara: 342-348)

If she initiates contact, the voice makes her doubt whether people really want her company and encourages her to interpret even a positive response negatively. For this reason, she tends to wait for others to contact her or invite her out, so that she is sure that it is their wish. This creates distance between her and others, impeding the formation of close relationships. In fact, it may even give the impression that she is not interested and drive others away, reinforcing her belief that others do not like her.

In a similar way, misinterpretation can happen in a therapeutic setting, making it difficult to access support. Alice describes her initial encounter with a psychologist.

The psychologist I saw [...] leafed through my history and she said quite irritably "I just don't understand, with your background, why your problems seem to be so severe" and it was that comment "seem to be so severe". [The voice convinced me that] she was either accusing me of manipulating, lying about the problems I was having or she meant given your background, like there's no history of abuse, parents didn't divorce, you come from a nice home, [so there is no reason for your difficulties]. (Alice: 402-412)

The psychologist had a tone that Alice perceived to be irritated and made a comment about her difficulties "seeming" severe. This triggered Alice's critical voice, which tends to blame her for her eating disorder and encourages her to distrust professionals. The clinician referring to her "background" made Alice feel like she should not have such severe difficulties given that she did not have a problematic childhood. I imagine the psychologist had no intention to trigger such feelings for Alice but the critical voice interfered to create a negative interpretation of the situation. Incidents such as this have the potential to interfere with treatment and with the establishment of a good therapeutic relationship. Whilst working clinically with eating disorders, I often witnessed similar misunderstandings between clients and staff and became aware of the need to choose my words very carefully.

The voice also directly causes participants to isolate. When they are experiencing frequent criticism and control by their inner voice, they are less likely to want to be around others.

[When the voice is present] I feel bad about myself and I'm a bit more withdrawn and might go and hang out in my own room rather than with other people or just be quite quiet if I have to stay with other people. (Erica: 187-191)

When Erica's inner voice is particularly critical she tends to withdraw and spend time alone. Alternatively she keeps quiet, remaining physically present but emotionally distant and preoccupied. This is likely to impede her capacity to form close relationships and seek support from others when she is having a difficult time.

Fiona's inner critic causes her to distance herself from her family as "a way of punishing myself" (Fiona: 601) because she does not deserve love and attention, according to the critical voice. It also affects her marriage.

It affects my marriage a little too, even though he's incredibly supportive and tries to understand what I'm going through, if I've had a bad day, if I've got those thoughts, I don't want to be close to him either, I push him away because I don't feel like I'm someone worthwhile, so I don't want [him] to see me. (Fiona: 608-614)

When she has had a difficult day she tends to push him away, she does not want to be seen because she does not feel like someone worthwhile. This creates a barrier to love and care from others, and keeps Fiona isolated despite having people who care about her in her life.

Similarly, Grace's voice often encourages her to keep her problems to herself.

If I have a problem [...] it's telling me "don't tell anyone". It's saying "no one's going to really care, no one's going to listen" or "people have their own stuff to deal with" which I've found is not really true because when I have said to people that I'm having problems or something's happened, [...] people are generally really nice. (Grace: 175-187)

Her critical voice tries to convince her that no one will care about her problems, she has therefore found it difficult to seek help for her eating disorder and generally. When she was able to open up to others more, she realised that this was not true – people did care and were supportive.

Iris had a unique experience since her boyfriend played an important role in her recovery. When they met, she started gaining weight and changing her behaviours and the voice would "tell me to dump [him]" (Iris: 635).

It would say "he's making you fat, don't eat that" or it would tell me to leave him because I'll be thinner and happier. So I felt really uncomfortable because [...] I was going through recovery and I was very happy being in a relationship but then [the voice] was really unhappy that I was putting on weight and it blamed [him] for putting on weight. (Iris: 647-653)

This left Iris feeling torn and created tension in her relationship but, fortunately, she was able to continue the relationship and recover. The voice attempted to create distance with others as a way to maintain the eating disorder's control – it is as if the voice were a companion competing for attention, and driving others away by encouraging distrust.

This theme describes the social impact of the critical inner voice. Participants say that the voice encourages them to interpret interactions with others in a critical or judgmental way, causing them to isolate for fear of not being liked or accepted. It can play a similar role in interactions with clinicians, creating distrust and preventing therapeutic engagement. It can also directly encourage isolation by telling participants that others do not care about them and that they do not deserve close relationships. It may also specifically encourage to distance people that are trying to help in recovery, as a way to keep the eating disorder in control.

3.2.4. Theme Group 4: Coping with the Voice

This group of themes deals with participants' experiences of addressing the voice in therapy, or generally trying to manage its impact. The first theme deals with participants' therapeutic experiences, other themes focus on specific techniques that participants have used in managing their critical inner voice. As this research is intended to inform clinical practice, I felt it was important to include all participants' views with regards to their therapeutic experiences and how they cope with the critical inner voice. As a result, some of the themes in this group represent fewer participants' experiences.

A. The Voice in Therapy

Three quarters of participants speak of their therapeutic experiences and reflect on how the critical voice may have been addressed. In doing so, participants' opinions about the effectiveness of various therapeutic approaches also emerge. They speak of CBT, as the prevalent therapeutic approach for eating disorders, including Third Wave CBT approaches. They also mention Mentalisation Based Therapy (MBT) and the role of psychoeducation in becoming their own therapist.

Brenda did not speak about her critical inner voice in therapy.

I never really covered [the voice] in therapy because a lot of the therapy I had was focused on stopping behaviours and coping with them, it didn't address the root cause. [...] A lot of the people that I spoke to accepted that this critical inner voice and this perfectionism is innate in people with eating disorders and that it's a personality trait. It was never properly addressed in therapy and I guess I hadn't really thought about it as an actual thing until I saw your research come through and I sat there and thought "yeah, I definitely have got a critical voice" but I hadn't really given it a [name] before I just knew that I was quite negative about myself. (Brenda: 251-263)

She describes her therapy as being mostly focused on coping with her behavioural difficulties rather than their cause. It appeared to her that clinicians simply assumed that self-criticism and perfectionism were innate in people with eating disorders and did not address them as problems or cognitive processes in themselves. Brenda had group CBT via the NHS which was focused on stopping eating disordered behaviours, there was no time to address the emotional aspects of eating disorders. Brenda was hoping to have more therapy to address these elements but she did not get the opportunity to do so.

She was also not fully aware of her critical inner voice until seeing the research advert for this study. She thought she had a negative attitude towards herself and perfectionistic personality traits but did not conceptualise them as a “voice”. Seeing the research advertised appears to have encouraged her to notice this aspect of herself. By engaging in the interview process, Brenda further reflected on her experience of the critical inner voice, which she found helpful.

Holly also had some CBT which she found somewhat helpful.

I have had CBT to try to help to manage [my self-critical thoughts] and I do think they are better than they were. Now I am aware of them whereas before I had any sort of help I didn't realise that it was a problem, I just thought that they were thoughts. I didn't realise the impact that they had upon me whereas I think having help is what enables you to be aware and have insight into the thoughts that you're having and the impact that they're having even if it means that you're not always able to challenge them. I don't think you can ever really erase that way of thinking but can find ways to challenge them rather than just accepting them. (Holly: 194-204)

She did focus on her self-critical thoughts in therapy and has become more aware of them and the impact they have on her as a result. She also found ways to challenge them, despite acknowledging that she cannot “erase” this way of thinking. Clara, on the other hand, thinks that CBT does not work well for anorexia as it is overly simplified, whereas the disorder is very complicated.

Erica is currently having CBT which she is finding helpful from a behavioural perspective but less so cognitively. Even when she manages to regularise her eating, she tends to get stuck when trying to change her thinking.

I found it quite hard to challenge [the voice] like I've been told, to challenge it and think of alternative things, [...] I could write down an alternative thought but I don't believe it at all so it just feels a bit pointless to me [...] I've had to do a few thought record things but [...] I just feel like I'm doing it for the sake of it, [...] so I could say “instead this is a more balanced thought” or “what's the evidence for or against this” but then it doesn't really even matter [...] when it doesn't really affect how much I believe it. (Erica: 210-230)

She finds it difficult to challenge her critical voice by using thought records. She can come up with evidence and alternative thoughts as an exercise but she does not believe them, which feels “pointless” and like she is doing the thought record “for the sake of it”. She also sometimes feels judged by her therapist, who can give the impression that she is not trying hard enough at challenging her thoughts.

I think she gets a bit irritated if I’m not trying, it makes me feel like I don’t want to write down the thoughts when I have them because then she’ll go “you shouldn’t think that” [...] it almost makes you feel bad for having the voice or having the thoughts. (Erica: 235-242)

It could be that this is Erica’s perception only but it is nevertheless important. It could also be a by-product of CBT as an approach, since aspects of it are rather didactic, with what can feel as “right” and “wrong” answers. This perceived judgment makes her feel guilty and has the effect of reinforcing her critical voice, which then begins to criticise her for having the thoughts she has or for not being capable of doing CBT properly. This process can also interfere with the formation of a good therapeutic relationship and causes Erica not to speak as openly.

Alice criticises CBT along similar lines. She can see how it is meant to work intellectually but she finds it too practical and it does not resonate emotionally. Furthermore, being the treatment of choice in the NHS and evidence based, creates the expectation that it should work.

I’ve met so many people who have struggled with CBT, and it’s all you get offered [...] if you first contact services [...] and I think there’s very much the sense that if it doesn’t work for you, you are failing. I think a lot of people are taking away the message that “CBT is really effective so if it doesn’t work for you, you’re not trying hard enough, you haven’t done enough homework” and I certainly felt that because it also connected with a lot of my own fears like “you’re being lazy, you’re not trying hard enough”. (Alice: 1066-1078)

She recalls meeting several people that have struggled with CBT because there is a sense that if it doesn’t work for you, then it may be your fault for not trying hard enough. For Alice, this reinforced her self-critical thoughts such as “you’re being lazy, you’re not trying hard enough” and became counterproductive. These criticisms of CBT are echoed in the literature and have formed the basis for Third Wave approaches.

Alice had another course of therapy which was a combination of Compassion Focused Therapy (CFT) and Acceptance and Commitment Therapy (ACT).

[The therapist] used a mixture of compassion focused therapy and acceptance and commitment therapy both of which I really liked because I hate CBT, I mean, I just find it clunky and like banging my head against a brick wall, but the acceptance and the values based work and the compassion were really helpful. It was like being able to hear that voice all the time and think “OK that’s my self-criticism voice” and just accept it and get on with what you’re doing nevertheless and look at what I aspire to in life and my values and how the [...] criticising voice, is alien from how I’d like

to live my life and the values that I have and how I would like to treat other people so I felt that that was a step forward. (Alice: 952-966)

Alice contrasts these approaches with CBT saying that she much prefers them. CBT felt like “banging my head against a brick wall” whereas the additional focus on acceptance, values and compassion that Third Wave approaches offer were more helpful. She was encouraged to accept her critical voice and coexist with it rather than challenge it. She focused on what was important to her instead, and realised that her values were not compatible with having such a strong critical voice. The focus on compassion was also particularly helpful.

The compassion based work [...] dealt with feelings, you know, “how do you feel emotionally hearing those thoughts?” I know they’re not rational, I can challenge them [...] but it doesn’t help with the experience of hearing them all the time, whereas I felt that the compassion based stuff helped, I think the therapist quite often said things like “it must feel awful living with that all the time” and actually I thought “you know what? it really is” and it’s no wonder I feel upset [...], it is fucking awful living with this constant self-criticism and the fact that I can challenge it intellectually doesn’t take away the hurt. (Alice: 1027-1041)

The therapist displayed empathy and compassion towards Alice, specifically for the fact that she had to live with her critical inner voice constantly. As a result, Alice was also able to be kinder to herself and she found this more helpful than challenging her thoughts, which felt rather punishing. Third Wave approaches felt “warmer, more about your feelings and who you are as a whole” (Alice: 1086-1089).

Alice also had some Mentalisation Based Therapy (MBT) which was helpful, particularly in addressing the interpersonal aspects of her critical voice.

I saw a mentalisation based therapist and that was great [...] in separating out what was in my mind and what his perceptions were, we did a lot of looking at the process between us [...] we’d have an opportunity to really look at everything that had gone on during the week, not just with me and him but with me and other people [...] and how I could deal with thinking “oh people must think I’m this or that, actually do you know what, they’ve probably got a lot going on...”. (Alice: 982-1006)

She focused on analysing interactions with her therapist and others and separating out her perceptions and thoughts from those of others. This approach was particularly helpful in dealing with the aspect of the voice which encourages misunderstandings and negative interpretations or where she imagines others thinking negatively of her.

Aside from therapeutic experiences, participants also mention finding it helpful to educate themselves about eating disorders and to find their own way to deal with the critical inner voice.

Clara speaks about the delays in accessing treatment and how she found it useful to learn about eating disorders in the meantime, she thinks that it was “easier and quicker to be your own therapist” (Clara: 448-450). It was particularly helpful to learn about the brain.

[Learning about the brain] stops me beating myself up when I [start feeling like] I'm a useless person if I can't like cope [...] I find it easier to be kinder to myself if [...] I know that my brain is very "fight or flight" [and] hyper-vigilant and it's not because I'm a useless person, it's how my brain works. (Clara: 532-538)

Understanding the neural processes underlying anxiety, for example, helped Clara to accept her distress rather than blame herself for it. As a result, she was able to be kinder to herself, rather than critical.

Alice also found it useful to learn about eating disorders.

I feel guilt for having had the problems that I've had and now I know more about it I am more compassionate. I think I know a lot more about the various factors why people develop problems like eating disorders and anxiety and there's a strong family background in my case. (Alice: 416-422)

It allowed her to feel less guilty about her problems and be more compassionate towards herself. It seems that psychoeducation can be particularly helpful in placating the aspect of the voice which criticises or blames participants for being unwell.

Fiona has a different view, she finds that intellectual understanding only helps to some extent.

I read all these books and tried any approach I could take to try to fix this, and eventually I realised it's just not an intellectual thing, I'm not going to get better by something I've read [...] it can be helpful, it can contribute to some things, but I think it does just come down to the emotional self-acceptance, I think that's the bottom line. (Fiona: 675-705)

In her opinion, dealing with the critical inner voice is about emotional self-acceptance. She does not link these two aspects the same way that Alice and Clara do, but she does recognise the value of learning about her difficulties.

This theme focuses on participants' experiences of therapy and how they may have addressed the critical inner voice. Not all participants specifically addressed the voice in therapy, for some there was more of a focus on behavioural change. Several participants had CBT interventions combining behavioural and cognitive techniques. Some participants found it helpful to challenge their critical voice whereas others found it difficult, resulting in further self-criticism and blame for not being able to do so. One participant found Third Wave approaches, with a focus on acceptance, values and compassion, more helpful in dealing with her self-critical thoughts. She also spoke highly of MBT's effectiveness in addressing the social and interpersonal aspects of the critical voice. Participants also found it helpful to educate themselves about eating disorders.

The following themes will explore in more detail specific techniques that participants have employed to deal with their critical inner voice, whether they are learned independently or through therapeutic interventions.

B. Challenging the Voice

Five participants speak of their experiences of challenging the voice, some of the techniques they mention are clearly borrowed from CBT, others may be specific to the participants.

Grace has been trying to challenge the voice by speaking back to it. She describes this as “not ideal but a step in the right direction” (Grace: 73- 75). She used to simply allow the voice to dictate how she should think or behave whereas lately it feels more like a “battle in my head” (Grace: 72). She got this idea from a book she read.

I’ve been reading a good book that has exercises to do and it says you should practice speaking back to it even if you don’t believe what you’re saying. So if I had to eat a big meal or something, the critical voice would be saying “don’t eat that” but then I would have to speak to it and say “no, I need to eat this” even if I don’t believe what [I’m] saying. So I’ve only just started doing that. (Grace: 157-164)

The book suggests speaking back to the voice even if one does not believe it, presumably in the hope that with time and practice one would begin to think differently and be more able to dismiss or change the critical voice. This is an interesting consideration and relates to the above-mentioned difficulties regarding not believing alternative thoughts. I wonder whether with time this would change, as the book implies. Grace has only just started practicing this technique, so it is probably too soon to say whether it is effective for her, but she seems hopeful.

Clara challenges her thoughts by questioning their validity.

I started developing the skills to think “is this my thought or is this a negative thought?” and doing a lot of fact checking so I got quite good at knowing something isn’t the case but then I still feel really anxious. (Clara: 382-390)

She is able to identify her negative thoughts and carry out “fact checking” effectively, but despite this, she still feels very anxious, it is as if the rational side of her were not able to connect with her emotions. Other participants also comment on how cognitive restructuring techniques lack an emotional focus. Theoretically, emotions are supposed to change as a result of thoughts changing, but for Clara and others this is not the case.

Clara also evaluates her inner voice by imagining she is talking to a friend in a judgmental way. She would not speak to others in this way and this realisation leads her to be kinder to herself.

I'll look at it as if I'm talking to a friend and say "well I wouldn't be judging a friend if.. if they'd eaten too much or and I certainly wouldn't think that they shouldn't spend time with me". (Clara: 413-418)

Iris uses a similar technique, which is to imagine her father saying what the voice says.

I try to change the voice and make it into something that would never happen, they would never say something [like that] to me, so my dad's voice is always a way of changing it because then it shows that it's not real and it's not something that should affect me. I used to try and argue against it but then it just became exhausting because [...] I was ending up having to rationalise something that is quite irrational and you were just arguing with yourself because whatever happened it would still make you feel awful even if you can see the you should do things and the right way. So if it wanted to say "stop eating" you'd say "well actually no 'cause I'm running six miles tomorrow" or "I'm really looking forward to this meal" it will still find a way to knock you down. (Iris: 362-377)

He would never say such things which shows that the voice is not real and lessens its impact. She prefers this approach to directly challenging the voice by arguing with it, which is exhausting and not particularly effective. Like Clara, she can rationally challenge the voice but this does not affect the way she feels. The voice is also particularly skilled at arguing back and, despite not being rational, it tends to find a way to be persuasive nonetheless.

Holly's awareness of her critical voice has improved over time and she is better able to challenge it but finds it tiring.

I think I am better at being aware of when I'm being critical of myself and trying to challenge it but that in itself is quite tiring I think, to always be thinking "you're being quite hard on yourself or would somebody else say that to you?". (Holly: 41-44)

She also mentions the technique of imagining someone else talking to her as the voice does. It appears that this is a technique that several participants find helpful.

It seems that most participants find it helpful to identify and challenge their critical inner voice. However this seems to have limited success in reducing their distress or changing their internal monologue. Several participants report finding this process tiring and comment that despite being able to challenge their critical inner voice rationally, it still maintains a hold on them emotionally.

C. Distancing the Voice

Seven participants speak of ways in which they try to distance their critical voice, whilst accepting that it exists. It seems that participants generally find this way of dealing with the voice more helpful than a direct challenge.

Clara explains how she differentiates between which aspects of the voice are helpful to challenge and which are best to simply dismiss and avoid engaging with altogether.

Some of it I find helpful to challenge, like with the perfectionist stuff, but with the eating disorder thoughts it's almost easier or better not to even engage with it and just be like "go away" 'cause it can be so manipulative if you try and engage and rationalise with it, it will always come up with more reasons so it's just better to go "no, it's not my thought, I'm eating breakfast, no I'm just turning the radio down". (Clara: 436-444)

Especialy with body focused thoughts I've learnt that I just literally say "I don't care" to it like a child. I think that I've probably learnt that from teaching when the children go "I don't care, I don't care" and it gets really annoying so it's like "I don't care, so what, I'm fat, I don't care" [but] if I try and rationalise "I'm not fat, I'm a healthy weight" I just can't, it just balances off and I can't believe it. (Clara: 458-465)

She finds perfectionistic thoughts helpful to challenge but not eating disordered thoughts. The latter can be very manipulative and difficult to rationalise with, so she finds it best to dismiss them. She disowns them by saying "it's not my thought" or imagines "turning the radio down" or saying "I don't care" to them.

Similarly, Alice thinks that finding ways to distance but coexist with the voice is often more realistic than challenging it or eliminating it.

I think to some extent it is part of me and I think it's as much about then finding ways to live with it and [...] be able to kind of laugh at it a little bit, like the ridiculousness, the absurdity of the tiny minute decisions which I hear [...] and so almost laughing at it and dismissing it is quite a helpful thing. (Alice: 795-803)

Laughing at it and dismissing it is helpful for her and creates distance, reducing the impact of the voice. She describes the voice as "absurd" and "ridiculous" which indicates her ability not to take it seriously.

Holly finds that simply keeping busy and distracted is helpful, so that she has less time to think critically. Similarly, Alice tries to be in the moment so that she is less aware of what is happening in her mind.

I'm trying to be more in the moment. I mean, I don't like mindfulness, I'm really not a big fan of it because it seems to exacerbate every perception in my body and then I feel hyperaware [...] but being more engaged with things outside is quite helpful sometimes, being immersed in the moment, I'm less aware of what I'm hearing in my own mind... [...] so being engaged and more present. (Alice: 902-912)

She compares this to a mindful state but focusing outwards, she explains that focusing on her body in a mindful way makes her hyperaware and can lead to critical thoughts about her shape and weight. I have experienced similar feedback from clients that I worked with in the past -

they appreciated mindfulness exercises based on observation or walking but did not enjoy breathing or body scan exercises for similar reasons.

Iris has found that the most helpful way to distance her critical voice is to write down what it says. She then goes through it with her boyfriend and they talk about the ways in which the voice has been trying to control her.

As soon as I've started to separate it that's when I've felt like it's not a part of me [...] definitely writing things down has helped because that means that I can remove it from my brain and share it with someone else so that they can see what I'm going through [...] makes it feel a bit like something you've shared rather than just kept to yourself. (Iris: 889-897)

I just wrote down exactly what it says and [my boyfriend] and I laughed about it later because it just sounds stupid on paper... you think "why would these words have so much of a control over the way you do things?" [...] seeing it on paper it looks less scary and a bit funny. (Iris: 312-318)

This enables her to separate the voice from herself and to share it with others, which helps others to understand her and makes it more bearable. She tends to read her notes with her boyfriend and sometimes they laugh about the absurdity of the things the voice says, which makes it seem less real and intimidating.

This theme outlines various ways in which participants are able to distance their critical voice to lessen its impact. They may try to shift their focus to being present and engaged with their environment and activities, which generally distracts them from their thoughts. They may also try to observe the voice and dismiss it, even laugh at its absurdity. Several participants agree that this is more helpful than trying to argue with the voice, as it is not rational and often finds ways to be persuasive and manipulative if they engage with it.

D. Soothing the Voice

Three participants also speak about finding it helpful to practice self-love and engage in soothing activities to soften the impact of the voice. Despite this theme not being as prevalent as others, I thought it important to mention, as it adds a different perspective to coping with the critical voice.

Brenda tries to counterbalance her critical voice with a more positive and loving voice. She also keeps a journal, writes music and paints to express her emotions freely.

I try and see if I can counter each negative critical voice bit with a positive thing. (Brenda: 249)

I journal a lot. I started keeping a more regular diary and I also write music and I paint. Generally speaking I find that if I can do something like that where I can pour my emotions out [...] in some way and that would relieve it a bit. (Brenda: 520-525)

In my experience working with eating disorders, clients have often found creative activities a useful way to express feelings and soothe critical thoughts.

Diana also finds it helpful to engage in pleasant activities that are nourishing and allow her to soothe her feelings, like reading or playing the piano.

I love books, it just takes you to another world [...] so I would try and do that and I used to play the piano, [...] so after I eat I would get these bad thoughts, I will try and do one of these things to help. (Diana: 219-225)

She chooses to specifically do these things after eating, when her critical thoughts are strongest. She also enjoys travelling.

In all of the annual leave that I've had I've done quite big trips [...] I think the voice is still there but at the same time I have so much other stimuli that it really helps trying to fight and beat that and that is quite nourishing. (Diana: 377-385)

The enjoyment and different stimuli that travel provides are helpful in distracting her from the voice and allowing herself to travel is a way to show love and care towards herself.

Fiona finds that allowing her emotions to flow freely is helpful.

I just try to be aware of the thoughts, be aware of the feelings, [...] don't put up any blocks, just let them go through, like one is not more important than the other [...] and if you catch yourself with these negative thoughts, just try to say something loving. Try to use mantras or something to take yourself out of that place. I think it depends on the day how effective it is. (Fiona: 409-416)

Having awareness of her thoughts and feelings without judgment helps to protect her against the critical thoughts she may experience. If they happen, she tries to say something loving to herself as well, as if she were talking to a child from a place of unconditional love.

I'll try to say "I love, respect and accept myself fully" and try to take whatever thought I had and turn it around. What I've learned is helpful is if I look at myself like a child, like how would you talk to a baby or your child, because I realise that all that self-love is, you know, treating yourself with unconditional love. (Fiona: 433-440)

She sometimes uses mantras such as "I love, respect and accept myself fully". She tries to focus on soothing the negative emotions that the voice brings. As the critical voice is not logical, she thinks it is difficult to overcome it with logic.

I think [the work needed to address the voice] is emotional because the voice doesn't tell me anything logical. Nothing the voice tells me is based on fact or reason or anything. [...] I think the only solution to quieting that voice is using another loving voice, using positive feelings and positive mantras, to remind myself of my value. (Fiona: 691-698)

She finds that using her “loving voice” and reminding herself of her value with unconditional acceptance are the most powerful tools in coping with her critical inner voice.

This theme outlines participants’ practices relating to self-love and acceptance. They describe finding it helpful to engage in activities that nourish them and allow them to express their feelings, such as creative pursuits and travelling. They also aim to counter their critical inner voice by using a loving, positive voice that comes from a place of unconditional acceptance.

3.3. Summary

In this chapter, I have tried to give voice to the experiences of the participants in an accurate and meaningful way. I have sought to convey the participants’ descriptions, reflections and suggestions relating to their experience of the critical inner voice. I am grateful to participants for their honesty and openness in sharing their personal experiences. I feel the interviews generated rich and insightful material to contribute to the existing body of research on this topic.

Throughout this chapter I have presented the themes that evolved out of the analysis process.

The first group of themes sets the scene by outlining participants’ accounts of how the voice came into existence and how it developed over time. It describes various factors which may have influenced the voice’s “birth” – from parental values and expectations, to innate personality traits and learned behaviour. It also covers the voice’s development over the course of their lives and how it relates to the development of their eating disorders. It appears that the voice may change or fade over time but never goes away completely. For this reason, it is an important phenomenon to study in the context of clinical interventions for eating disorders.

The second group of themes focuses on how the voice manifests itself. Participants hold that the voice plays a central role in precipitating and maintaining their eating disorders by way of criticizing their weight and shape and encouraging eating disordered behaviours. The voice also affects participants’ lives in a broader way by criticizing everything they do and encouraging perfectionistic tendencies. In addition, the voice may also act as a motivator, which can be helpful and possibly one of the reasons why it is so difficult to eliminate.

The third group of themes aims to convey what it is like for participants to live alongside their critical voice. It encompasses participants’ experiences of the voice from a cognitive and relational perspective, showing that the voice manifests itself on a spectrum ranging from being experienced as a thought to being associated with a personified entity. It also describes the voice’s circular and relentless nature which impacts on participants’ eating disorders as well as

their lives in general. Lastly, participants describe the voice's social impact which creates isolation and prevents help seeking.

The fourth group of themes outlines participants' efforts to cope with the voice. It covers how participants may have addressed the voice in therapy and what they find helpful or unhelpful in reducing its negative impact. Overall, it seems that participants find engaging with their critical inner voice in a confrontational manner is less helpful compared to distancing the voice or counter balancing it with a non-judgemental, accepting and self-loving attitude.

Chapter 4: Discussion

4.1. Introduction

This study aims to investigate how women affected by eating disorders experience the phenomenon of the critical inner voice. From the literature review it has become apparent that there is a limited amount of existing research on this topic and therefore this study has the potential to create new knowledge that can shape the understanding and treatment of eating disorders as well as inform further research. The interpretative phenomenological analysis of participants' interviews yields four groups of themes as a representation of the key experiences relating to the phenomenon of the critical inner voice.

In this chapter, I will review each theme group and further explore the material by linking the findings to existing literature and identifying areas where new knowledge or ideas for future research may emerge. I will then discuss the study's implications for the discipline of Counselling Psychology and evaluate the strengths and limitations of this research. Afterwards, I will make suggestions for future research resulting from the analysis and discussion of the findings. Lastly, I will reflect on the personal impact I may have had on the study.

4.2.1. Theme Group 1: A Lifetime of the Voice

This group of themes captures the participants' descriptions of how the voice evolves over time, from its origins to the present day. It encompasses participants' accounts of how the voice may have come into existence, as a combination of parental influences, early learning and innate personality traits. It also outlines how the voice evolves over time, from when participants start becoming aware of it, through different stages of illness and recovery. The theme names reflect the fact that participants often speak of the voice as having a life of its own. This quality has also been highlighted in existing accounts and research (Bruch, 1978; Claude-Pierre, 1997; Kortink, 2008; Fathallah, 2006; Hendricks, 2003; Higbed & Fox, 2010). As will be explored further on, the degree of distance between participants and their critical inner voice can vary widely. On the other hand, the way participants perceive the voice's onset and development is more homogenous.

Several participants mention family values and early experiences as contributing to the beginnings of their critical inner voice. They speak of high expectations and values of excellence

and success being present in their families. They also speak of critical parents whose voices have become a part of their inner life. There is no available research on the link between parental behaviour and critical inner voices in eating disorders, however some research exists on the link between parental behaviour and the critical inner voice in general terms. Several authors hold that the inner critic partially finds its origins in the parent-child relationship (Stinckens et al., 2013). Where parents have been critical, intrusive, controlling and demanding, the individual may judge themselves in the same way. Studies have shown that parents who set high standards for their children and excessively criticize them when failing to meet these standards, contribute to the development of an inner critic (Glassman et al., 2007; Yates et al. 2008). Some would therefore describe the inner critic as an introjected, critical parent figure (Bergner, 1995; Blatt, 1995; Rugel, 1995).

Participants also recall noticing parents being critical and judgmental towards themselves and say that this may have served as a model for their critical inner voice. Research has found that self-criticism can arise from modelling others' behaviour in how they treat themselves, most notably parental behaviour (Andrews, 1998; Gilbert, 1998). Psychoanalytic thought also offers some considerations on the critical inner voice and its link to parental behaviour. Firestone (1986) holds that the process behind the formation of the critical voice includes the incorporation of the parental attitudes and defences. Clinical evidence suggests that the voice relates directly to rejecting thoughts and attitudes of parents, both overt and covert, that have been incorporated by the child. Critical and derogatory attitudes toward the self are often identified as statements they either heard from their parents or as attitudes they picked up in their parents' tone of voice, body language, or other behavioural cues (Firestone, 1986). These can encompass the way that parents criticise themselves as well as critical and demanding attitudes towards their children.

It is also interesting to note that there is an established link between obsessional traits and critical parenting within psychoanalytic theory and practice (Kainer, 1979). Although not directly related to eating disorders, these considerations can be relevant as it has been found that eating disorders are often associated with obsessive thoughts and compulsive behaviours, which often maintain the conditions (e.g. Naylor et al., 2011; Hoffman et al., 2012). Several participants in the study do in fact describe themselves and their parents as having obsessive personality traits. According to Kainer (1979) it is common that severely obsessional patients have at least one parent who is harshly critical. The voice of the parent then becomes a critical voice which perpetuates obsessional thoughts and behaviours later in life. Kainer observes that her obsessional patients often have parents who would criticise their physical appearance, school performance and all aspects of their being. The children are somehow made to feel that no

matter what they do, they are doing wrong. Their parents are often also obsessive and anxious themselves, further providing a model of behaviour and a likely genetic inheritance. These observations are certainly true for some participants, who report internalising their parents' criticism and attitudes towards themselves into their critical inner voice.

Several participants also speak of their critical inner voice as being closely linked to personality traits such as being perfectionist, obsessional and self-conscious – characteristics that they attribute to observational learning in childhood, as well as genetic inheritance. There is extensive research available on the correlation between these personality traits and eating disorders but less so on the interaction between them and the critical voice. A large body of evidence links some of these traits to the aetiology of eating disorders (Treasure & Cardi, 2017). Perfectionism, rigidity and other aspects of obsessive-compulsive personality have been noted to precede the onset of eating disorders (Fairburn et al., 1999; Karwautz et al., 2001; Kim et al., 2014; Stice & Shaw, 2002) and have been found to be common in family members (Cederlof et al., 2015; Lilenfeld et al., 1998). Perfectionism is the trait most commonly mentioned by participants as giving rise to their critical inner voice. It can be defined as a personality disposition characterized by striving for flawlessness and setting exceedingly high standards of performance accompanied by overly critical evaluations of one's behaviour and fear of negative evaluations by others (Flett & Hewitt, 2002). Several studies have related perfectionism to all eating disorders (e.g. Bastiani et al., 1995; Kaye et al., 1998; Pratt et al., 2001). A distinction is made between self-oriented perfectionism (critical self-scrutiny, unrealistic self-imposed personal standards, requiring perfection of oneself) and socially-prescribed perfectionism (perceiving that others are demanding perfection of oneself and the need to achieve standards and goals indicated by others) (Flett & Hewitt, 2002). Empirical research shows that self-oriented perfectionism is specifically closely related to the development of eating disorders (Bastiani et al., 1995; Castro-Fornieles et al., 2007). This type of perfectionism is also more typical in eating disorders compared to other diagnoses such as depression or anxiety disorders (Castro-Fornieles et al., 2007). The focus on self-oriented perfectionism certainly also transpires from participants' accounts of the critical inner voice, as will be further discussed in relation to later themes.

Participants also describe the development of the critical inner voice over time, and how it relates to their eating disorder. Most participants recall first becoming aware of their critical inner voice around puberty, in close proximity to the development of their eating disorder. Previous research on the critical inner voice does not mention this detail, however it is well

known that the onset of eating disorders typically occurs in adolescence (e.g. Mcparland, 2008; NICE, 2017). Further research has found that recollections of disliking the physical changes of puberty predicts eating disorder symptoms years later (Moore et al., 2016). Participants in this study also describe puberty as a difficult time from a social and physical perspective. Following its onset, the voice then evolves in different ways for each participant. For some participants the critical voice begins to focus on general topics and then shifts to focusing on eating disorder related topics, for others it is the other way around. For most participants, the voice creeps in slowly, initially feeling somewhat helpful but then becoming negative and controlling. This type of pattern is also described in existing research (Nordenboos et al., 2014; Tierney & Fox, 2010). Tierney and Fox (2010) find that the anorexic voice evolves over time in a similar way. It initially draws participants in when they are feeling particularly vulnerable, it provides comfort, assists in decision making and self-improvement. It then gradually changes over time and becomes controlling and abusive. The study also describes a third phase where participants realise the voice is harmful and they end the “relationship”, creating a sense of loss (Tierney & Fox, 2010). This phase is partly reflected in this study – participants do eventually realise that the critical voice is harmful, however they do not report ever losing it. On the contrary, they say that it stays with them beyond recovery and that it is something that they continue to coexist with. The pervasive nature of the critical inner voice over time, and its close link to the development of eating disorders, means that addressing it in psychological interventions could play an important role in the prevention and treatment of eating disorders.

4.2.2. Theme Group 2: The Voice in Action

This group of themes describes the content and functions of the critical inner voice in relation to participants’ eating disorders as well as more generally. Participants speak of the voice and their eating disorder being one and the same - the voice drives the eating disorder by criticising them and telling them what to do. They also talk about how the voice impacts their life in general, aside from their eating disorder. Most descriptions of the voice within this group of themes are framed in a negative way, with the exception of the last theme in which the voice displays some positive characteristics as a motivating force in participants’ lives.

Participants hold that the voice is what drives their eating disorder and that their symptoms are a consequence of having a critical and controlling inner voice. Participants differentiate between criticism and behavioural instructions coming from the voice. These two aspects are also captured by the Self-Talk Scale (Brinthaup et al., 2009) as “self-critical self-talk” and “self-managing self-talk”. Unsurprisingly, self-critical self-talk is found to be negatively associated with

self-esteem (Brinthaup et al., 2009) and positively associated with anxiety (Ren et al., 2016). Furthermore, frequent self-talkers score higher than infrequent self-talkers on obsessive-compulsive tendencies (Brinthaup et al., 2009). Although not directly related to eating disorders, these findings demonstrate that self-talk may play a role in mental health difficulties. Participants describe different types of criticism coming from the voice, which tend to focus on their shape, weight and eating habits and therefore encourage eating disordered behaviour. Criticisms tend to centre around being “lazy”, “disgusting”, “fat”, “greedy”. Existing research on the anorexic voice also reports similar critical messages (Tierney & Fox, 2010; Williams & Reid, 2012; Wade, 2003) – it is usually experienced as an inner commentary on shape, weight, eating and their implications for self-worth (Pugh & Waller, 2016). These topics clearly echo the core psychopathology of all eating disorders (Fairburn, 2008).

It is interesting to note that certain critical aspects of the voice described by participants bear a close resemblance to typical cognitive distortions which, according to CBT, can maintain mental health difficulties (Beck, 2011). Participants describe how the voice generalises and filters information to make criticism more effective. “Overgeneralisation” involves seeing a single negative or unpleasant incident as evidence of everything being negative. This way of thinking is often applied to body image by participants, for example, where there is evidence that a participant might be looking unattractive in a specific context, the voice will take the opportunity to generalise this to all situations and continue criticising them for their appearance constantly. Applying a “mental filter” involves paying undue attention to some details and not others, thus reinforcing maladaptive thinking as true. This type of process often applies to comparisons with others, for example the voice will selectively compare participants to others who fare better in weight, shape or eating habits, causing participants to think negatively of themselves and therefore maintaining the eating disorder. Another cognitive distortion that the voice draws upon is “all-or-nothing thinking”, whereby situations and characteristics are viewed as polarised and extreme, rather than on a continuum (Beck, 2011) – this process leads criticism to become more extreme, rather than constructive or nuanced. Similarly, clinical observations from a humanistic perspective have noted that the inner critic tends to be “non-nuanced” and has a tendency to generalise (Stinckens et al., 2013). Its attacks are predictable, simplistic and generalized, it uses terms like “always” and “everyone” with authority, giving it a veneer of invulnerability (Stinckens et al., 2013).

Participants in the study also highlight that the critical voice tends to adapt to the circumstances and stages of recovery as relevant, to maximise its effect. One participant notes that during periods of restriction, the voice drives this by criticising her for her eating habits, whereas during periods of weight gain due to recovery, it criticises her body more. During recovery the voice

also tends to criticise participants for not working hard enough to get better. This may seem like a paradox but could indirectly encourage participants to give up on recovery and relapse into their eating disorder. These features of the critical inner voice are not described in existing literature, indicating how the present study is contributing new knowledge and illuminating areas for further study. Being aware of the ways in which the voice may adapt to different stages of illness and recovery can be helpful in treatment, so that clinicians can adjust their approach accordingly, particularly when it comes to relapse prevention.

In addition to criticism, the voice also provides behavioural instructions to participants, directly encouraging them to engage in eating disordered behaviours like restriction or excessive exercise. The voice also makes use of the above criticisms to control participants' behaviours more effectively. Similar types of instructions are reported by Tierney and Fox (2010) in their study with anorexic patients, with the voice portrayed as a controlling and powerful entity, dictating what they should do and degrading them for failing to abide by strict rules and standards of behaviour. A further study by the same authors (2011) similarly describes living with the voice as a "prison-like" existence, dominated by rules and harsh punishment for breaching them. Participants' accounts also repeatedly refer to rules and conditions that must be met in order to "deserve" to eat or rest, failure to meet these conditions often results in punishment by means of having to comply with even stricter standards. Unfortunately, as later themes will explore, the voice is never satisfied and a vicious cycle is created. The voice can be seen as enforcing eating disordered behaviours and standards around weight, shape and diet as oppressive conditions of worth (Rogers, 1951) that participants must meet in order to be good enough. Research shows that relying on appearance as a source of self-worth is linked to elevated body surveillance and decreased appearance satisfaction (Overstreet & Quinn, 2012), a relationship which is likely to fuel the circular nature of the critical inner voice and its role in the maintenance of eating disorders.

The vast majority of participants mention that the voice criticises and controls them in ways that are not directly related to their eating disorder. They experience criticism relating to all aspects of life, from work to interpersonal relationships and general performance. The voice also encourages them to be productive and have high standards in all endeavours. Conversely, others experience the voice as putting them down to the extent where they believe they are not capable of anything, lowering their self-esteem and paralysing them. Previous research on the critical inner voice in eating disorders touches on the voice's encouragement of perfectionistic tendencies relating to eating disordered behaviour and generally (Tierney & Fox, 2010; Nottelman & Thijssen, 2010; Wade, 2003), however it does not explore the various types of

criticism and control that the voice exerts on individuals aside from their eating disorder. The present study elaborates on this theme, adding valuable detail to the body of research on this topic.

Stinckens's taxonomy of types of inner critic (2013), which was developed from the systematic analysis of therapy sessions, can serve as a useful guide to identify the key features of the critical inner voice as described by participants in this study. The critical inner voice criticises participants for everything they do and makes them feel like they are never good enough. This function of the inner critic is highlighted by Stinckens et al. (2013) as the "degrading/undermining critic" which, over time, causes individuals to have a negative self-image. They may feel defective, insignificant, incompetent or unloved (Stinckens et al., 2013). The critical voice also makes it difficult for participants to be kind to themselves or even allow themselves basic necessities because they are not worthy. These features of the critical inner voice are like the "punitive/accusatory critic" which is insulting and punitive and causes individuals to treat themselves harshly and deny themselves compassion or forgiveness (Stinckens et al., 2013). The voice keeps score of their actions and goes beyond any reasonable standards in its demands and evaluations. This can be compared to the "overdemanding/controlling critic" which encourages individuals to hold themselves to unachievable standards and ideals (Stinckens et al., 2013). This happens in a professional setting but also encourages productivity and performance excessively in their personal lives, making it difficult to relax and enjoy themselves. It encourages constant activity and meticulous planning and, if participants rest, it causes them to feel guilty and anxious. This indicates that the voice plays an important role in regulating emotions by encouraging excessive activity and potentially compulsive behaviours in any aspect of life, not just as related to disordered eating. Previous research has in fact shown that inner speech can act as a self-regulatory and motivational tool (Alderson-Day & Fernyhough, 2015; Winsler & Naglieri, 2003; Winsler et al., 2003) which can be helpful but can also become dysfunctional.

For some participants, there also comes a point where the voice encourages them to give up on their pursuits – rather than encouraging them to work hard, it becomes invalidating and paralysing. Criticism and instructions can lead to the avoidance of challenging or new situations. This is often framed in a protective way – the voice tries to convince participants that it is not safe to do anything that may cause rejection or judgement from others, or that simply makes them stand out. This aspect of the voice is similar to the "distant/avoidant inner critic" that encourages a cynical or pessimistic attitude towards others or activities and causes individuals to hold back and avoid (Stinckens et al., 2013). The critical voice can also encourage participants to please others in order to be loved and accepted. If others cannot be pleased or do not show

approval, the voice will blame them. Participants assess their value on others' perceived evaluation as they are unable to consider themselves worthy or good enough. They cannot show "unconditional positive regard" (Rogers, 1951) towards themselves. This feature of the voice is similar to the "subservient/neglectful critic" which encourages subservient and self-deprecating behaviour and looking for affirmation out of fear of conflict or rejection (Stinckens et al., 2013). This aspect of the voice may create dynamics whereby individuals associate with people that abuse or mistreat them (Stinckens et al., 2013).

As I reflect on the first two themes in this group in relation to the literature, it is apparent that they encompass many different aspects and functions of the critical inner voice. The themes could have been grouped by function rather than separated between eating disorder related and general themes. Both approaches would be meaningful and helpful but the way I have devised the themes arose out of the transcripts directly and therefore remains truer to the ethos of IPA. On the other hand, themes that reflect the different functions of the critical voice would be more in line with existing research on inner speech and the inner critic. Given that this study is intended to be exploratory and focused on the experiences of individuals suffering from eating disorders, I feel that it is helpful to separate the eating disordered elements of the voice from the general elements, so that they can be compared and contrasted. As will be mentioned later, further quantitative research focusing on what functions the critical inner voice plays for individuals with eating disorders would be helpful to build on the findings of this study.

The third theme in this group highlights a unique aspect of the voice – it can be helpful as a motivating force and has enabled some participants to achieve more than they would have otherwise. It could be seen as the positive side to the above aspect of the voice which pushes participants to work excessively hard. Perhaps this is part of the reason why it is so difficult to eliminate the critical voice – in order to do so participants may also lose this valuable element. Although participants speak favourably of the motivational aspect of the voice, this may not be entirely beneficial to their wellbeing. Research shows that perceiving the voice as benevolent is linked to more pathological eating attitudes in anorexia (Pugh & Waller, 2017). This perceived positive aspect of the voice may therefore play a part in maintaining eating disorders. Participants say that the voice encourages them to achieve academically and professionally and that, without it, they may not be as driven or successful. As already mentioned, inner speech can act as a self-regulatory and motivational tool (Alderson-Day & Fernyhough, 2015; Winsler & Naglieri, 2003; Winsler et al., 2003) which can be helpful. A similar type of inner speech, according to the Varieties of Inner Speech Questionnaire (McCarthy-Jones & Fernyhough, 2011), is "evaluative/motivational inner speech" which can serve the function of evaluating one's behaviour as well as motivating. This is the most common type of inner speech in the general

population but is also associated with traits of anxiety and depression, as well as lower self-esteem (Alderson-Day et al., 2014). This exemplifies the dual nature of the critical inner voice which can act as a motivator but can also be indicative of mental health difficulties.

Participants describe how the same voice can quickly turn from something that inspires them to achieve to something that crushes them. One participant describes how she can tell the two types of voice apart – the motivating voice is rational and tells her things that other people may also say to her whereas the critical voice is unreasonable and extreme in its demands. This sounds similar to the CBT technique of “distancing” questions that can be used to challenge automatic thoughts (Beck, 2011) where one imagines telling the same thing to a friend, or conversely imagines someone else speaking those words. This tends to invalidate or distance the thoughts and helps in challenging them. These observations could be helpful in treatment, where clinicians can help patients distinguish between the aspects of the critical voice that are valuable and those that are destructive. The way in which the voice can have a dual role is similar to the difference between adaptive and maladaptive perfectionism. The adaptive dimension emphasizes a focus on high standards for oneself while the maladaptive dimension emphasizes self-criticism and being overly concerned with mistakes (Blankstein & Dunkley, 2002; Dunkley et al., 2006). Both types of perfectionism are correlated with disordered eating (Bardone-Cone, 2007; Bardone-Cone et al., 2007; McGee et al., 2005). Similarly, both motivating and critical inner voices are described by participants in the study. Other literature on the subject, however, suggests that individuals diagnosed with an eating disorder tend to be self-critical with the intent of harming and persecuting themselves more than with the intent of promoting self-improvement (e.g. Barrow, 2007).

4.2.3. Theme Group 3: Living with the Voice

This group of themes outlines some key aspects of living with the critical inner voice that are felt to be important by a large proportion of participants. In the first theme participants describe how they experience the voice from a cognitive and relational perspective, as a constant internal commentary to their lives coming from a different part of themselves. The second theme describes the voice as a relentless vicious cycle which impacts on their eating disorder as well as their lives in general. Lastly, participants describe the voice’s social impact – it encourages suspicion and isolation.

Participants describe the voice as a constant and automatic cognitive process, however there is some variation as to how they perceive the voice in relation to themselves, some participants

compare the voice to thoughts whilst others perceive it as coming from a different part of themselves or may experience a personified entity associated with it. The relational aspect of the critical inner voice appears to manifest along a spectrum, with variation across as well as within participants' experiences. Participants' descriptions of the critical inner voice indicate that it is an involuntary cognitive process rather than an auditory hallucination – they are conscious that it is internally produced rather than externally generated. This is in line with existing research on the anorexic voice which describes it in similar ways and compares it to inner speech (Pugh, 2016; Highbed & Fox, 2010). Participants describe the voice as similar to thinking and it provides a constant automatic commentary to their lives. This is consistent with theories of inner speech that consider it equivalent to thinking (Watson, 1913) although, as detailed in the literature review, it is also much more than that. Inner speech plays an important role in the self-regulation of cognition and behaviour (Alderson-Day & Fernyhough, 2015) and it would therefore make sense that it is always present. Individuals suffering from eating disorders present with dysfunctional cognitions and behaviours which are likely to be linked to cognitive processes like inner speech and the critical inner voice. Existing research on inner speech also shows that it may be involved in the representation of every day mood states (Calvete et al., 2005) and cognitive models of psychopathology hold that cognitive processes underlie mental health difficulties, playing a crucial role in their maintenance (Beck, 2008). Some participants do indeed experience the critical inner voice as an internal monologue in the first person, which could be seen as similar to negative automatic thoughts from a CBT perspective (Beck, 2008).

Other participants experience the voice in the form of an inner dialogue. Inner speech is also referred to as an internal monologue or dialogue in the literature - according to Vygotsky (1987), inner speech is in fact a reflection of linguistically mediated social exchanges that are internalised and transformed into a conversation with the self. The link between inner speech and overt language is considered to be “private speech”, which is the process of talking to oneself out loud (Vygotsky, 1987). One participant describes the critical inner voice as manifesting like an internal process that can be externalised by talking out loud, and vice versa. The content, however, remains the same, indicating the strong link between spoken language and the critical inner voice. Participants also report that the dialogue may also take the form of an argument between the eating disordered side and the more rational side of themselves. This echoes existing qualitative research on the experience of eating disorders, where they are often described as a psychological battle between two parts of the self (Broussard, 2005; Ross & Green, 2011; Cranston, 2011). Most participants identify the voice as their own, but it often sounds angry and punitive, as if coming from a different part of themselves. Similar descriptions

are also found in accounts of the experience of the critical inner voice (Bruch, 1978; Wade, 2003).

Participants sometimes experience the voice as a personified entity but still internal. One participant finds it difficult to disentangle her critical inner voice from her abusive mother's voice. Existing literature on the anorexic voice also draws the parallel between living with the voice and being in an abusive relationship (Tierney & Fox, 2011), whereby the voice is a source of comfort and support but also a controlling force which encourages individuals to engage in eating disordered behaviour. The abuser undermines participants' confidence and leads them to believe that life without it is impossible (Tierney & Fox, 2011). Another participant, on the other hand, imagines the voice of someone resilient, who has overcome adversity. This makes her feel ashamed by comparison, which compounds the critical content of the voice. It is well known that self-criticism and shame are often experienced by individuals with eating disorders (e.g. Duarte et al., 2015; Goss, 2007). Individuals with high levels of shame and self-criticism often talk to themselves in a cold, aggressive way to try and change the way they are feeling or behaving (Gilbert, 2009) and this can create a vicious cycle.

All participants describe the voice as relentless and circular in nature, so that complying with it may quieten it temporarily but eventually reinforces it, creating a vicious cycle which maintains the eating disorder. The circular nature of the voice also sabotages recovery and impacts on life choices, sometimes leading to a self-fulfilling prophecy and failure, which further reinforces the critical inner voice. Participants feel that, whether they satisfy the voice's demands or not, they will suffer negative consequences – they will either remain unwell or feel extremely guilty and frustrated. Existing research has found a similar pattern of the voice becoming increasingly taxing in its demands and pushing participants to extremes, with ever shifting goalposts (Tierney & Fox, 2010). Participants also say that restricting food intake can cause the voice to be strengthened, encouraging more restriction and creating a loop. This is likely to be partly due to starvation effects, which include low mood, anxiety, irritability and obsessive thoughts about food and generally (Brozek, 1950). Participants also mention a different kind of cycle which affects recovery. The voice will criticize their ability to get better and overcome disordered eating, which impacts on their confidence regarding recovery and can lead to viewing any lapse as a relapse, creating a self-fulfilling prophecy. This highlights the importance of relapse prevention as part of any treatment plan. Fairburn (2008) suggests that it is important for patients to have realistic expectations about recovery and to accept that there may be some lapses. A greater awareness of the process of recovery could prevent the critical inner voice from taking hold during lapses and contributing to more serious relapses.

Aside from their eating disorder, the voice also encourages participants to take on challenging tasks, particularly in their work. This is driven by perfectionistic tendencies and the need to achieve to prove to themselves that they are good enough. Two participants describe choosing particularly challenging careers which facilitated the maintenance of their critical inner voice. Eventually they felt that the only way to break free from this cycle of self-criticism and perfectionism was to leave their fields of work, which was perceived as a failure, reinforcing their self-critical beliefs. Clinical perfectionism of this kind has also been found to interfere with treatment response (Fairburn, 2008). It can be defined as a state in which perfectionism is so pronounced that the person's life is significantly impaired (Shafran et al., 2002). It can include the over-valuation of achievement and the rigorous pursuit of high standards despite this having adverse effects on actual performance. Not meeting such standards may culminate in a very critical self-evaluation. Meeting standards, however, does not reduce the urge for perfection and the standard is often set higher (Shafran et al., 2002). Conversely, as has been outlined in previous themes, perfectionism can also cause avoidance of challenging situations or tasks for fear that one's performance will not be good enough (Fairburn, 2008). Addressing clinical perfectionism in treatment is important, as it can intensify aspects of eating disorders, making them more difficult to overcome (Fairburn, 2008). The CBT-E protocol devised by Fairburn (2008) suggests including clinical perfectionism interventions in the treatment of eating disorders if relevant, with the aim of reducing the over-evaluation of achievement and enhancing other domains of self-evaluation.

The critical inner voice also has a significant impact on social and affiliative process. It encourages participants to be suspicious of others and to expect judgment and criticism from them. Participants tend to be concerned with how they are perceived socially and the voice leverages these concerns to create self-doubt and wariness of others. It often tells participants that others do not like them or that they cannot be trusted. It also encourages negative interpretations of others' words to this effect, which may impede the formation of close relationships and foster isolation. A similar process is noted in existing research on the anorexic voice, whereby the voice will demand an exclusive relationship and attempt to turn participants away from people by twisting their motives (Stinckens et al., 2013; Tierney & Fox, 2010). Despite these demands for exclusivity, the relationship with the voice is far from equal, with the voice in a position of dominance (Stinckens et al., 2013). Furthermore, research on self-criticism, which is closely related to the critical inner voice and highly present in individuals with eating disorders, also shows that self-critical individuals often fear affiliation (Gilbert et al., 2011). Further observations on the phenomenon of the inner critic have also highlighted its effect on

interpersonal dynamics. It causes individuals to look to others for affirmation and makes them oversensitive to criticism (Stinckens et al., 2013).

The critical inner voice may also encourage isolation by distancing others that may be trying to help, which also maintains the eating disorder. Specifically, misinterpretation of others' words or behaviours often takes place in a clinical setting. This can cause participants to interpret interactions with clinicians to be judgemental or critical and can lead to disengagement from treatment. I have frequently experienced this when working with eating disorders and it is an important point for professionals to be aware of. It is as if the critical voice and eating disorder mindset act as a filter for all interactions, interpreting them in a way that maintains the eating disorder. It seems that the critical inner voice interferes with mentalisation, the process by which we make sense of ourselves and others, and therefore affects participants' sense of self and mutuality in relationships (Daubney & Bateman, 2015). It follows that a mentalisation based therapeutic approach may be helpful in dealing with the critical inner voice.

4.2.4. Theme Group 4: Coping with the Voice

In this group of themes, participants reflect on their experiences of addressing the voice in therapy and describe specific techniques they find helpful in managing it. In doing so, participants' opinions about the effectiveness of various therapeutic approaches also emerge. They speak of CBT, which is the prevalent therapeutic approach for eating disorders, including "third wave" CBT approaches, they also mention Mentalisation Based Therapy (MBT). Some express that clinicians often consider that self-critical and perfectionistic attitudes are innate in people with eating disorders and therefore the critical inner voice is not directly addressed in therapy. Participants largely communicate that they think it would be helpful for therapeutic interventions to address the voice more directly. Existing research holds that addressing the critical voice during treatment is essential to help individuals overcome their eating disorders (e.g. Davies, 2008; Dolhanty & Greenberg, 2007). One approach that allows for this to happen is Emotion Focused Therapy (EFT). Overall, participants find that engaging with their critical inner voice in a confrontational manner is less helpful compared to distancing the voice or counter balancing it with an accepting and self-loving attitude.

Most participants speak of their experiences with CBT and note that in this approach there is a strong focus on changing behaviours. The CBT-E treatment protocol devised by Fairburn (2008) does indeed advocate a focus on behaviour change in its core treatment. It does not make use of formal cognitive restructuring, as it holds that such techniques are not needed to produce

cognitive change in the context of eating disorders. Rather, it suggests that the most powerful way of achieving cognitive change is by helping patients change the way they behave and then analysing the effects and implications of those changes (Fairburn, 2008). It seems, however, that some participants have engaged in CBT approaches that do make use of cognitive restructuring techniques. They generally find that evaluating thoughts and changing them into more rational thoughts is not particularly helpful and does not lead to a change in emotions. CBT theory has several ways of conceptualizing why the evaluation of automatic thoughts may be ineffective. These include that the evaluation of the thought may be too superficial or inadequate, that the automatic thought is itself a core belief, or that the evidence has not been sufficiently explored (Beck, 2011). Participants find other techniques preferable to a direct challenge of the voice, such as imagining saying what the voice says to a friend or imagining someone who cares about them saying those things to them. These approaches show that the voice is not real and lessen its impact, rather than changing its content. These techniques also originate from CBT and are referred to as “distancing” (Beck, 2011).

Participants have also attempted to challenge the voice by speaking back to it, which is described as a step in the right direction but also exhausting. Participants describe a “battle” in their head and find it hard to argue with the voice because, despite not being rational, it tends to be particularly skilled at arguing back and being persuasive. This cognitive technique is based on the premise that self-defeating beliefs can be changed by demonstrating their irrationality through engaging in an inner dialogue to refute them (Burns, 1992). This may work in the short run but it requires constant effort and may cause internal conflict (Andreas, 2014). Just as people in the real world do not like to be disagreed with, internal voices are no different and are likely to become defensive and double their efforts to be convincing (Andreas, 2014). Andreas proposes alternative ways of dealing with negative self-talk, based on change principles. These include joining in with the voice, understanding its true intent and redirecting it. He holds that arguing with or silencing the inner voice may simply lead to frustration and failure (Andreas, 2014).

Whilst participants find that CBT is overly focused on behaviour change, they also acknowledge that it is most helpful from a behavioural perspective and less so in changing thoughts and feelings. While the approach raises awareness of their critical thoughts, cognitive restructuring techniques are considered too simplistic to address eating disorders. As described above, challenging the critical inner voice or negative thoughts with cognitive techniques is often found difficult by participants. They say that they can come up with evidence or alternative thoughts and understand them intellectually, but they find them difficult to believe and their feelings

remain the same. Furthermore, if they are unable to challenge their thoughts they report feeling guilty and frustrated, which reinforces the aspect of the critical inner voice that criticizes them for being unable to overcome their eating disorder. It is this sort of feedback on CBT, alongside theoretical advances, that has set the foundation for the development of “third wave” CBT approaches. Whereas the majority of cognitive and behavioural therapies in the first and second wave are relatively mechanistic and presuppose that cognitions lead directly to emotional and behavioural consequences, third wave approaches focus on understanding and accepting the processes behind cognitions and behaviours (Hayes, 2016). The emphasis is on second-order change strategies such as acceptance, mindfulness, metacognition, and psychological flexibility (Hayes et al., 2011) instead of first-order cognitive restructuring which is more direct. Given participants’ feedback on second wave CBT, it could be that incorporating elements of third wave CBT approaches like Acceptance Commitment Therapy (ACT) or Compassion Focused Therapy (CFT) may be beneficial in the treatment of eating disorders.

One participant specifically references ACT - she finds the concept of acceptance particularly helpful in relation to the critical inner voice. Focusing on her values also allows her to realize that they are not compatible with the values of the critical voice, which helps to give her life a more meaningful direction. ACT does in fact have at its core the objectives of accepting internal events that cannot be changed whilst committing to taking values-driven action (Hayes et al., 1999). Participants also mention that they generally find it easier to distance the critical inner voice and coexist with it rather than challenge it. This description is similar to the concept of “defusion” in ACT. It involves separating or distancing our thoughts, letting them come and go instead of being caught up in them (Harris, 2009). Defusion can be encouraged by noticing the process of thinking and by learning experientially that our thoughts and internal experiences do not control our actions or our feelings (Harris, 2009).

Participants also mention that being aware of their thoughts and allowing them to exist freely and without judgement is helpful. This concept is similar to a mindful stance towards one’s thoughts and feelings, whereby one pays attention to their experience in the present moment with openness and curiosity, without judgement (Harris, 2009). Mindfulness is specifically mentioned by one participant, she says that she finds it helpful in dealing with the critical inner voice as long as there is an external focus to the practice, such as mindful observation, listening or walking. Breathing exercises or body scans, on the other hand, have a tendency to make her hyper-aware of her body and can lead to critical thoughts. Mindfulness is an awareness process, as opposed to a thinking process, and can therefore help disengage with problematic thoughts, including the critical inner voice. It involves paying attention to our experience in the present

moment with openness and curiosity (Harris, 2009). The rationale for including mindfulness skills as a component of therapy for eating disorders rests on the proposition that, by cultivating mindful awareness, we can facilitate self-acceptance, cognitive flexibility, compassion for self and others, and generally improve the ability to respond adaptively to disturbing emotions (Katterman et al., 2014). ACT also encourages mindfulness practice as way to encourage defusion (Harris, 2009). It seeks to weaken the link between unpleasant internal experiences and subsequent maladaptive behaviour, without necessarily altering the internal experiences themselves (Hayes et al., 1999). Cusack (2014) finds a significant correlation between low psychological acceptance and disordered eating. There is also evidence that therapeutic approaches based on ACT can be effective for eating disorders (Juarascio et al., 2013; Clark, 2014; Walloch, 2014).

Focusing on compassion is also found helpful by participants. When clinicians express compassion and empathy about participants' experience of the critical inner voice, it enables them to gain a new perspective towards the voice and become more compassionate towards themselves, rather than joining in with the voice in criticising themselves. CFT was specifically developed to address shame, self-criticism, and self-directed hostility by developing the capacity for compassion (Gilbert, 2009; 2010). This involves being open to compassion from others, towards others and towards oneself (Gilbert, 2014). CFT addresses the critical inner voice directly and includes exploring the experience of self-criticism, how it began and developed over time, what functions it serves and what it protects against (Gilbert, 2010). CFT conceptualises self-criticism in terms of critical comments, dialogues and feelings within the self, and therefore acknowledges the presence of the critical inner voice. Feelings of warmth and kindness can also be encouraged through a variety of activities such as compassionate attention, compassionate reasoning and compassionate imagery (Gilbert, 2009). Similarly, participants find it helpful to counterbalance their critical voice by using a more positive and loving voice towards themselves and by engaging in soothing activities. Participants explain that a soothing approach to the voice is found to be more helpful than a rational one like challenging the voice because the voice is not rational. Clinicians can support clients to develop a more compassionate relationship with themselves by demonstrating the skills and attributes of compassion (Gilbert, 2009). Evidence for the effectiveness of CFT in treating eating disorders has been encouraging (Gale et al., 2012).

One participant mentions MBT and says that she finds it particularly helpful in mitigating the interpersonal impact of the critical inner voice. By focusing on mentalisation, it allows for the

consideration of alternative interpretations of social interactions, other than those that are encouraged by the critical inner voice. This is particularly helpful in dealing with the aspect of the voice which suggests negative interpretations of others' words or intentions. MBT can also help individuals to understand their own internal experiences more effectively, leaving them more emotionally stable and with a stronger sense of self (Daubney & Bateman, 2015). Although only one participant has experience of this approach, it could be widely applicable given the interpersonal difficulties that most participants experience. Impaired mentalisation has been found to be a central psychopathological feature in anorexia nervosa (Skarderud, 2007). Furthermore, it has been observed that breaks in mentalising due to unbearable emotional states can often be linked to the onset and maintenance of eating disorders (Robinson, 2014). MBT can also help to distinguish between bodily sensations and mental representations, so that the emotional components of body image and appetite concerns can be better understood. An MBT protocol for the treatment of eating disorders was developed and tested in a randomised controlled trial and found to be effective (Robinson, 2014).

As previously mentioned, participants generally note that treatments for eating disorders tend to have a strong focus on behaviour change and cognitive processes and are less focused on emotions. They call for a stronger focus in therapy on the feelings that the critical voice is associated with. EFT may therefore be a helpful approach, with its focus on experiencing emotions and exploring their meaning and context in order to differentiate between what are adaptive and maladaptive emotions. In doing so, EFT promotes greater acceptance of the self and of internal experiences, as well as restructuring maladaptive emotional responses (Dolhanty & Greenberg, 2009). Furthermore, EFT includes specific techniques for working with the critical inner voice in a relational way – Gestalt chair work is used to facilitate resolving internal splits involving the critical inner voice (Dolhanty & Greenberg, 2009). When a part of the self is critical or coercive towards another, a two chair dialogue is employed where the two parts “speak” to each other with the goal of determining the impact and function of the critical voice (Dolhanty & Greenberg, 2009). EFT has been found effective in the treatment of bulimia and binge eating disorder (Wnuk et al., 2015; Gilsenti et al., 2018).

Overall, participants' experiences of coping with the critical inner voice provide helpful considerations that could guide further development of treatment approaches for eating disorders.

4.3. Summary

The findings of this study highlight the central role that the critical inner voice plays for individuals suffering from eating disorders. It accompanies them throughout their lives and is often present before and after the acute phase of their eating disorder. This research explores the experience of the critical inner voice in detail, including how it relates to eating disorders and how it impacts participants' lives overall. A key finding of this study, which was not explicit in previous literature, is that the critical inner voice pervades participants' lives beyond their eating disorder and is often linked by participants to inheritable personality traits and early experiences. Key relational, cognitive and emotive features of the critical inner voice are also discussed and related to existing literature. Notably, the voice manifests itself in several ways and appears to change form depending on the circumstances and stage of recovery, often creating a vicious cycle which maintains eating disorders and participants' overall self-critical mindset. Participants speak extensively about how they have learned to cope with the critical inner voice and how it has been addressed in therapy. Their feedback on therapeutic approaches is particularly valuable, as are their suggestions on how to cope with different aspects of the voice.

The description and interpretation of participants' experiences, combined with considerations relating to existing academic and clinical literature, contribute valuable new knowledge which is directly applicable to the treatment of eating disorders. Furthermore, the broad focus of this study, encompassing all eating disorders, combined with a detail oriented analysis of the experience of the critical inner voice, provides a wealth of information that may inform further research in the field of eating disorders.

4.4. Strengths and Limitations of the Study

There is a limited amount of literature on the subject of the critical inner voice in individuals with eating disorders, so this study contributes substantially to creating new knowledge. It also bridges the gap between different areas of research, such as cognitive psychology, psychotherapy and counselling psychology, and relates them to the critical inner voice in eating disorders. The literature review and discussion of the findings encompass a unique combination of perspectives on the subject, including clinical considerations, a cognitive viewpoint and a variety of methodological approaches.

Yardley (2000) proposes four broad principles for the evaluation of qualitative research: sensitivity to context, commitment and rigour, transparency and coherence, impact and importance. These characteristics were kept in mind throughout this research and were

considered in detail in the Methodology chapter. In what follows I will discuss the key strengths and limitation of the study.

Using a qualitative method allows for the detailed exploration of participants' individual experiences but, on the other hand, it does not allow to generalize findings to the wider population. IPA is interested in how a particular phenomenon is subjectively experienced while also allowing the researcher to look across cases and examine what is shared or unique (Smith et al., 2009). IPA findings can therefore give an indication of the likely experiences of others in similar situations (Smith & Osborn, 2003). Since research is scarce in this area, a qualitative methodology was helpful for an initial exploratory study. It allowed me to immerse myself in the lived experience of participants and produced rich data. Furthermore, the National Institute of Clinical Excellence (NICE, 2017) highlights that patient experience is a key element to consider when developing therapeutic approaches. Since one of the objectives of this research is to inform clinical practice, a qualitative approach was considered the best fit.

The sample size of this study was in line with the recommendations for IPA (Smith et al., 2009). Nine interviews were conducted, which is a larger than average number for IPA studies. This was primarily due to the high response level to the research advert, which I believe was an indication of the relevance of this topic to individuals with eating disorders. I therefore felt the responsibility to capture a wide range of perspectives and to give voice to as many participants as possible. At the same time the interviews were analysed in depth which ensured quality.

Smith et al. (2009) recommend that participants should be part of a homogeneous sample. By making sure the participant group is as uniform as possible, one can consequently examine more effectively the variability within that group. The sample for this study was homogenous in respect of the shared experience of the critical inner voice and eating disorders, as well as gender. It also happened that all participants identified as white, the majority of them attained university level education and were in their 20s. As considered in more detail in the Methodology chapter, it could be argued that the sample could have been more homogenous. However, participants were intentionally heterogeneous in terms of diagnosis and stage of recovery as this study was intended to be exploratory and informed by research that supports a shared psychopathology across all eating disorders.

4.5. Suggestions for Further Research

This study explores a topic which is under researched and also an important aspect of the experience of eating disorders, as evidenced by the high level of interest from potential participants, some of whom were unable to take part. The response rate is a phenomenon in

itself and indicates that the research topic is highly significant. It follows that further qualitative and quantitative research in this area would be feasible and worthwhile to inform the understanding of eating disorders as well as clinical practice.

The majority of research on eating disorders has been conducted on women since eating disorders are more prevalent within this group. However, new studies are aiming to explore the male experience to reflect the increase of eating disorders amongst men (e.g. Hudson et al., 2007; Lavander et al., 2010). It would be interesting to investigate the experience of the critical inner voice in a male population. Furthermore, it might be interesting to research whether individuals diagnosed with different eating disorders experience the critical inner voice differently. The experience of the critical inner voice could also be explored at different stages of recovery or after receiving specific treatment interventions.

This topic could additionally be researched from a quantitative perspective, with endless possibilities. As detailed in the literature review, several questionnaires have been developed to capture inner speech and they may be employed to capture elements of the critical inner voice as well. It would be interesting to conduct studies where such questionnaires are administered to individuals suffering from eating disorders alongside questionnaires of eating disorder psychopathology. It would be possible to then understand which aspects of inner speech are highly correlated with symptoms of eating disorders. Measures of different constructs that have been observed in this study could also be included, such as self-esteem, self-compassion, self-acceptance and perfectionism. Studies could also compare similarities and differences between men and women or across different disorders. Other methodologies devised to study inner speech, such as experience sampling, could also be applied to the study of eating disorders, with possibilities for cross-discipline studies encompassing developmental psychology, cognitive neuroscience, and psychopathology.

4.6. Implications for Counselling Psychology

The findings of this study demonstrate the crucial role played by the critical inner voice in eating disorders. This is in line with previous qualitative research which indicates that underlying psychological factors are felt to be more important by eating disorders sufferers than physical symptoms (e.g. Tierney & Fox, 2010; Williams et al., 1993). This study provides new and detailed insights that may help clinicians in understanding and treating eating disorders. The aim of this section is to provide a summary of key suggestions that may inform clinical practice for counselling psychologists and other mental health professionals.

The critical inner voice seems to accompany participants throughout their lives. It plays an important role in maintaining their eating disorder as well as affecting them overall. Family values and early experiences appear to contribute to the development of the critical inner voice. It may be rooted in the parent-child relationship, especially where parents have been critical, controlling or setting high standards for their children (Stinckens et al., 2013; Glassman et al., 2007; Yates et al., 2008). Parents modelling a self-critical attitude towards themselves may also contribute to the development of the critical inner voice. It may be therefore helpful to explore such relationship dynamics in a therapeutic context, if this is felt to be relevant.

The critical inner voice may also be linked to personality traits that are common in individuals suffering from eating disorders, such as perfectionism, rigidity and obsessiveness (e.g. Treasure & Cardi, 2017; Fairburn et al., 1999). Self-oriented perfectionism seems to be most relevant to the critical inner voice and is closely related to the development of eating disorders (Bastiani et al., 1995; Castro-Fornieles et al., 2007). Interventions addressing perfectionism may therefore be helpful in mitigating the critical inner voice. These may be found in the CBT-E protocol developed by Fairburn (2008), for example. Other approaches, particularly third wave CBT approaches, may also be helpful in counterbalancing perfectionistic and self-critical tendencies.

Individuals first become aware of their critical inner voice around puberty, in conjunction with the development of their eating disorder. The voice tends to creep in slowly, initially feeling somewhat helpful but then becoming abusive and controlling (Nordenboos et al., 2014; Tierney & Fox, 2010). The voice may change over time but it tends to remain with participants beyond recovery. It follows that addressing the voice in psychological interventions could play an important role in the treatment of eating disorders. Furthermore, preventative interventions that address the critical inner voice and related experiences may be helpful. These could be included in secondary school education, when children are most vulnerable to developing eating disorders and other mental health problems.

The voice plays a central role in participants' experiences of eating disorders, it criticizes participants and provides behavioural instructions. Participants report that the critical inner voice is often not directly addressed in therapy and they suggest that labelling it and exploring it would be helpful. It is felt that therapeutic interventions focus mostly on changing behaviours, whereas more attention should be given to cognitive and emotive aspects of eating disorders, such as the critical inner voice. CBT is considered helpful by participants to raise awareness of their critical inner voice but cognitive restructuring techniques are largely found ineffective mostly due to the inability to change individuals' emotional state. The didactic nature of CBT can also affect the therapeutic alliance because patients may feel blamed for having a critical inner voice that they should be able to change. Challenging the voice may be effective in the short run

but requires constant effort and may cause internal conflict (Andreas, 2014). Alternative strategies like joining in with the voice and redirecting it may be more effective (Andreas, 2014). An emphasis on second-order change strategies such as acceptance, mindfulness and psychological flexibility may also be more helpful than first order cognitive restructuring (Hayes et al., 2011).

The concept of acceptance may be helpful in dealing with the critical inner voice and coexisting with it, along with the emotions that may come with it. A focus on values may also encourage a more constructive life direction. ACT encourages “defusion” by distancing thoughts rather than being caught up in them which may also be helpful in dealing with the critical inner voice (Harris, 2009). A focus on developing self-compassion may also be effective in countering the critical inner voice by encouraging a kind and non-judgmental attitude towards oneself (Neff, 2003). CFT would also address the critical voice directly by exploring its development over time and its functions (Gilbert, 2010). Adopting a mindful stance can also help to distance the critical inner voice. Mindfulness practices that are externally focused are found to be more helpful, rather than those which focus on the body which may exacerbate body image concerns. Developing mindfulness skills may improve the ability to respond adaptively to disturbing thoughts and emotions (Katterman et al., 2014), including the critical inner voice.

The critical inner voice has a substantial social and relational impact. It encourages suspicion, social comparison and isolation. Previous research also notes that self-criticism experienced within eating disorders includes an element of fear of affiliation (Gilbert et al., 2011), which can lead to interpersonal difficulties. The voice appears to act as a filter for all interactions, interpreting them in a way that maintains the eating disorder. MBT may offer helpful interventions in this domain – by focusing on mentalisation, it allows for the consideration of alternative interpretations of social interactions, other than those that are encouraged by the critical inner voice. MBT can also help individuals to understand their own internal experiences more effectively and it can help to distinguish between bodily sensations and mental representations, so that the emotional components of body image and appetite concerns can be better understood (Robinson, 2014). EFT is another approach that may be helpful in dealing with the critical inner voice, with its focus on experiencing emotions and allowing them to guide the therapeutic process. EFT promotes greater acceptance of the self and of internal experiences, as well as restructuring maladaptive emotional responses (Dolhanty & Greenberg, 2009). Furthermore, EFT includes specific techniques for working with the critical inner voice using Gestalt chair work (Dolhanty & Greenberg, 2009).

The critical inner voice affects individuals’ lives beyond their eating disorder. It may also play a self-regulatory and motivating role in their lives (Alderson-Day & Fernyhough, 2015; Winsler &

Naglieri, 2003; Winsler et al., 2003). It encourages high standards and can lead patients to be driven and high-achieving. However, it can quickly turn from being supportive to being crushing and invalidating, becoming so critical that its effect is paralyzing. For this reason, it is important for patients to be able to tell the difference between a voice that is fuelled by adaptive or maladaptive perfectionism, both of which are highly correlated with disordered eating (Bardone-Cone, 2007; McGee et al., 2005). Maladaptive or clinical perfectionism has been found to interfere with treatment response (Fairburn, 2008). It may also be helpful for individuals to identify the different functions and forms that the critical inner voice may take for them – the taxonomy developed by Stinckens and colleagues (2013) can serve as a useful guide.

4.7. Personal Reflections

I am grateful to have had the opportunity to engage with participants and their experiences. I felt a good rapport was established during the interviews and participants reported finding it helpful to share their experiences in this context. Several participants also told me that they participate in research on a regular basis, with a wish to contribute to treatment approaches for eating disorders and improve their understanding. I hope that clinicians and researchers will benefit from the insights highlighted in this study. Engaging in this research has certainly had a profound impact on me as a clinician and as an individual.

I was particularly struck by the vast similarities in participants' accounts, as well as their individual differences. I was able to include most of the material from the interviews in my analysis, as the themes were rather evident and common across participants. Participants were at different stages of recovery, therefore the way they presented their experiences varied. Some were very sure of their accounts and had reflected on their experiences extensively already whereas others were more improvised and spontaneous in their answers. It was interesting to notice the interaction style in each interview, although this was not explored in detail in my findings.

During the interviews, and while analysing the data, I also wondered how my presence influenced participants' accounts. I realise that the critical inner voice often comments on interpersonal and social aspects of participants' lives and therefore I may be included in these comments. Most participants did not ask me any personal questions nor spoke about their perception of me but I wonder what they may have been thinking or what their critical voice may have been saying. I wonder how they perceived our similarities and differences regarding age, appearance, culture, social status or other characteristics.

Carrying out this research was by far the most challenging aspect of my qualification as a Counselling Psychologist, and consequently brought up much anxiety and self-doubt. However, I am comforted by the fact that so many participants found the research topic relevant. There were several more participants that came forward and that I was unable to interview, which shows that there is scope for further qualitative and even quantitative research on this topic.

4.8. Conclusion

This study explores the complex and multidimensional construct of the critical inner voice for individuals diagnosed with eating disorders. This phenomenon manifests itself in diverse ways but also displays many commonalities. I explored the origins and development of the critical inner voice, its content and process and how participants cope with it. I expected that it would be an important aspect of participants' experiences but I was surprised to learn that it is much more than that. It appears to be the central feature of their eating disorders – underpinning behavioural, cognitive and emotive symptoms. It follows that a more direct focus on the critical inner voice and its ramifications would be beneficial in the treatment of eating disorders.

Participant's accounts of the critical inner voice highlight the need to pay attention to its origins and multiple functions in the context of eating disorders and beyond. They also challenge the effectiveness of CBT in addressing the critical inner voice effectively, due to its focus on behavioural and cognitive change, which can clash directly with the content of the voice and therefore cause more distress. They suggest that third wave CBT approaches may be helpful in addressing the critical inner voice by encouraging acceptance, self-compassion and mindfulness. Furthermore, MBT and EFT approaches can be helpful in dealing with the relational and emotive aspects of the voice, which are highlighted as particularly important by participants.

This study also brings together different areas of research and practice that are relevant to the understanding of the critical inner voice. It encompasses perspectives from cognitive psychology, psychotherapy and counselling psychology, creating a platform for further research on an interdisciplinary level which will hopefully enhance the understanding of the critical inner voice experienced by individuals diagnosed with eating disorders.

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Appendices

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Appendix 1: Interview Schedule

What made you decide to come along?

When did you first become aware you may be experiencing difficulties with eating?

Do you experience a voice that comes along with your ED? When did you begin experiencing a critical inner voice?

Can you tell me about a recent time when you experienced this voice? What was it like? How did you feel?

What does the voice say?

What is it like to experience this voice?

What does the voice sound like?

How is the voice helpful? How is it unhelpful?

Has the voice changed over time?

Does the voice serve a function? What is the function(s) of the voice for you?

When is this voice present?

What happens when you experience it?

How do you think your life would be without the voice?

What do you like / dislike about the voice?

How do you imagine the voice to evolve in the future?

Where do you think this voice came from?

Do you think the voice is connected to your eating disorder?

How much time in your day does the voice take up?

Have you addressed the voice in therapy and how?

How does the voice impact different aspects of your life?

Is the voice saying anything now/today?

Prompts/going deeper – Can you tell me a bit more about that? What do you mean by...?
Why? How? How did you feel?

Appendix 2: Demographic Questionnaire

Name

Age

Ethnicity

Education

Occupation

Relationship status



**Department of Psychology
City University London**

**PARTICIPANTS NEEDED FOR
RESEARCH ON EATING DISORDERS**

We are looking for volunteers to take part in a study on the experience of the “critical inner voice”.

If you have been diagnosed with any eating disorder and experience an inner voice that judges you, criticizes you or tells you what to do, we would appreciate your contribution to this research project.

You would be asked to take part in an interview – this would involve speaking to the researcher about your experience for up to 1 hour.

For more information about this study, or to take part,
please contact:

Elena De Giacomini [REDACTED]

Supervisor: Courtney Raspin [REDACTED]

This study has been reviewed by, and received ethics clearance through the Psychology Department Research Ethics Committee, City University London - *PSYETH (P/F) 15/16 142*.

If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee on 020 7040 3040 or via email: [REDACTED]

Appendix 4: Participant Information Sheet



CITY UNIVERSITY
LONDON

Eating disorders and living with the "critical voice"

INFORMATION SHEET

We would like to invite you to take part in a research study. Before you decide whether you would like to take part, it is important that you understand why the research is taking place and what it would involve for you. Please take time to read the following information carefully and feel free to ask if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

This research aims to explore your experience of the "critical inner voice" that may judge you, criticize you or tell you what to do. We know that this is quite a common experience for people with eating disorders and we want to find out in more detail how this voice manifests itself. Your participation will provide valuable information that may contribute to the treatment of eating disorders. The study will contribute to the research component of a Professional Doctorate in Counselling Psychology at City University.

Why have I been invited?

You are an adult who has been diagnosed with an eating disorder (anorexia nervosa, bulimia nervosa, binge eating disorder or another specified or unspecified eating disorder) and you report experiencing a "critical inner voice".

Do I have to take part?

Participation in the project is voluntary and you can withdraw at any stage without being penalised or disadvantaged in any way. If you decide to take part you will be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason.

What will happen if I take part?

You will participate in an interview with the researcher that should last no longer than an hour. This will involve talking to the researcher about your experience of the "critical inner voice". During the interview you may be asked questions to clarify and explore your experience further. You may decide not to answer any questions that you are not comfortable with without providing a reason for doing so.

What are the possible disadvantages and risks of taking part?

It is possible that the interview process could be distressing to some participants as sensitive material may be addressed. Should you have any concerns about the research study or the information you have provided, please speak to the researcher after the interview.

What are the possible benefits of taking part?

Many participants tend to enjoy taking part in this sort of research. It is an opportunity to explore and reflect on your journey and experiences which could be valuable as part of your therapeutic work and personal growth. You will also be making a valuable contribution to the development of new treatment approaches.

Will my taking part in the study be kept confidential?

Your name will not be used or appear in any aspect of the research project. Audio recordings of the interview will be used solely for analysis by the researcher. The tapes will not be heard by any other person unless shared in confidence with the research supervisor or other research collaborators. All data will be stored securely and confidentially, with consent forms separated from data files. All identifying variables will be removed from transcripts and audio-recordings. Any data shared with others in the research process or any quotes included in the published research will be anonymized.

Anything you share in your interview will be confidential unless you disclose information that concerns harm to yourself or others or any criminal activity, in which case, only that information may be shared. We will notify you of this in advance whenever possible.

What will happen to the results of the research study?

The research study will be published as a doctoral thesis and will be stored at City University Library. The researcher and the supervisor may also publish any excerpts as individual academic papers. Anonymity of participants will be maintained at all times.

What will happen if I don't want to carry on with the study?

You are free to withdraw from the study without an explanation or penalty. Should you wish to do so, please contact the researcher within a month of your interview date. Later withdrawal will interfere with data analysis and will therefore not be possible.

What if there is a problem?

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: [Eating disorders and living with the "critical voice"]

You could also write to the Secretary at:

Anna Ramberg
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London
EC1V 0HB
Email: Anna.Ramberg.1@city.ac.uk

City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Who has reviewed the study?

This study has been approved by City University London Psychology Department Research Ethics Committee, approval number *PSYETH (P/F) 15/16 142*.

Further information and contact details

If you have any questions about the study after taking part, you may contact the researcher, Elena De Giacomini at [REDACTED] or the supervisor, Dr Courtney Raspin at [REDACTED].

Thank you for taking the time to read this information sheet.

Appendix 5: Consent Form



Eating disorders and living with the "critical voice"

CONSENT FORM

Ethics approval number: PSYETH (P/F) 15/16 142

Please initial box

1.	I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve <ul style="list-style-type: none">• being interviewed by the researcher• allowing the interview to be audiotaped	
2.	This information will be held and processed solely for research analysis by the researcher and the tapes will not be heard by any other person unless shared in confidence with the research supervisor or other research collaborators. I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation. I consent to the use of sections of the audio transcript in publications.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

Name of Researcher

Signature

Date

Name of Participant

Signature

Date

When completed, 1 copy for participant; 1 copy for researcher file.

Appendix 6: Sample of Table of Final Themes

Coping with the Voice

The Voice in Therapy	Challenging the Voice	Distancing the Voice
<p>495-500 I had like a.. it was mainly.. it was like a group session, CBT. A lot of it was about um trying to stop damaging behaviours before moving onto the addressing the emotional side and because it's NHS, the.. the length of care just isn't quite, that they prescribe for you, isn't just.. isn't quite long enough</p>	<p>382-390 I do a lot of fact checking. [...] I started sort of developing the skills to sort of think "well, is.. is this my thought or is this a sort of negative thought" and like, yeah, doing a lot of fact checking and yeah so I got quite good at knowing something isn't the case but then I still feel really anxious.</p>	<p>795-803 I think to some extent it is part of me and I think it's as much about then finding ways to.. to live with it and [...] be able to kind of laugh at it a little bit, you know, like just the ridiculousness, the absurdity of the tiny minute decisions which I hear [...] and so almost kind of just laughing at it and dismissing it is quite a helpful thing.</p>
<p>479-486 I remember finding CBT a bit.. it just doesn't.. well I don't think it works very well for anorexia like 'cause it's so complicated [...] I just found it was all.. it always, always really over-simplified</p>	<p>71-75 as I've gotten a bit better I've definitely become more kind of able to have a battle in my head. Whereas usually it would just be the critical voice that would win whereas now it's more like an argument which isn't ideal, but I think it's kind of a step in the right direction.</p>	<p>298-307 the way that's been the most helpful to me is um writing it down so I have this little booklet at home so if I ever hear anything or I'm kind of cooking and it suddenly wants me to not eat something or do something else um I write down what it says and um sometimes it could be kind of like a couple of things like "stop eating" or um "no more" or "you don't need that" um and then other times it might kind of criticise the way I look so I'd write it all down and then I'd go through with my boyfriend</p>
<p>1085-1090 the warmth and the compassion and the acceptance and the values that felt warmer, more ab.. more about your feelings and who you are as a whole. [...] and for me that's what has made the difference.</p>	<p>210-232 I found it quite hard to like challenge it like I've been told to sort of like challenge it and think of alternative things, I just find it hard to.. I don't know, like I could write down an alternative thought but I don't believe it at all um so it just feels a bit pointless to me um I guess like I might have become a bit more conscious of like catching myself when I do have negative thoughts um 'cause sometimes I can just like not even notice it um yeah and I've had to do a few of the like sort of thought record things um but yeah, as I said, I find it quite hard to like.. like I'll write all the stuff I'm supposed to write but I just feel like I'm sort of just doing it for the sake of it.</p>	<p>458-465 especially with sort of like body focussed thoughts I've just learnt that I just literally say "I don't care" to it like a child. I think that I've probably learnt that from teaching when the children go "I don't care, I don't care" and it gets really annoying so I just kind of do that to it and it's like "I don't care, so what, I'm fat, I don't care" and so like it's almost if I try and rationalise "I'm not fat, I'm a healthy weight" I just can't.. it.. it just balances off and I can't believe it so if I just sort of go "I don't care, I don't care" like, yeah.</p>

Appendix 7: Reflexivity Questions

1. Why am I carrying out this study?
2. What do I hope to achieve with this research?
3. What is my relationship to the topic being investigated? Am I an insider or outsider? Do I empathise with the participants and their experience?
4. Who am and how am I influencing the research I am conducting in terms of age, sex, class, ethnicity, sexuality, disability and any other relevant cultural, political or social factor?
5. How do I feel about the work? Are there external pressures influencing the work?
6. How will my subject position influence the analysis?
7. How might the outside world influence the presentation of findings?
8. How might the findings impact on the participants? Might they lead to harm and, if so, how can I justify this happening?
9. How might the findings impact on the discipline and my career in it? Might they lead to personal problems and how prepared am I to deal with these, should they arise?
10. How might the findings impact on wider understandings of the topic? How might your colleagues respond to the research? What would the newspapers make of the research? Does the research have any implications for future funding (of similar research and/or related organizations)? What political implications might arise as a result of the research?

(Langridge, 2007)

Appendix 8: Ethics Approval Letter



CITY UNIVERSITY
LONDON

Committee

Psychology Research Ethics

School of Arts and Social Sciences
City University London
London EC1R 0JD

18th February 2016

Dear Elena De Giacomini and Courtney Raspin

Reference: PSYETH (P/F) 15/16 142

Project title: An insight into the critical inner voice often experienced by those suffering with eating disorders

I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee.

Period of approval

Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period you will need to apply for an extension using the Amendments Form.

Project amendments

You will also need to submit an Amendments Form if you want to make any of the following changes to your research:

- (a) Recruit a new category of participants
- (b) Change, or add to, the research method employed
- (c) Collect additional types of data
- (d) Change the researchers involved in the project

Adverse events

You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee [REDACTED], in the event of any of the following:

- (a) Adverse events
- (b) Breaches of confidentiality
- (c) Safeguarding issues relating to children and vulnerable adults
- (d) Incidents that affect the personal safety of a participant or researcher

Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch.

Kind regards

Hayley Glasford

Student Administrator

Email: [REDACTED]

Katy Tapper

Chair

Email: [REDACTED]



Eating disorders and living with the "critical voice"

DEBRIEF INFORMATION

Thank you very much for taking part in this research and for your time and effort. Your participation is greatly valued.

As previously mentioned, the purpose of this study is to explore your experience of the "critical inner voice". We know that this is quite a common experience for people with eating disorders and we want to find out in more detail how this voice manifests itself. Your participation will provide valuable information that may contribute to the treatment of eating disorders.

Your anonymity will be ensured and the audio recording will be stored safely. Once the study is completed all data will be destroyed.

If your participation has raised any discomfort or if you feel concerned about any of the information you have disclosed, you may speak to the researcher after the interview. Should you wish to, you may also discuss some aspects of the interview with your personal therapist or contact your GP. Alternatively, some easily accessible sources of support are:

Samaritans: Provides confidential, non-judgmental emotional support for people experiencing feelings of distress or despair, including those that could lead to suicide. You can phone, email, write a letter or in most cases talk to someone face to face.

Telephone: 08457 90 90 90 (24 hours a day)

Email: jo@samaritans.org

Website: www.samaritans.org

Beat: The UK's leading charity supporting anyone affected by eating disorders or difficulties with food, weight and shape. Beat provides helplines offering support and information about eating disorders and difficulties with food, weight and shape. They also have an email service and online support groups.

Telephone: 0345 634 1414 (1pm - 4pm)

Email: help@b-eat.co.uk

Website: www.b-eat.co.uk

We hope you found the study interesting. If you have any other questions please do not hesitate to contact us.

Researcher: Elena De Giacomini

E-mail: [REDACTED]

Research Supervisor: Dr Courtney Raspin

E-mail: [REDACTED]

Ethics approval code: *PSYETH (P/F) 15/16 142*

SECTION B: CLIENT STUDY

A Cognitive Behavioural Approach to Working with Excessive Use of Internet Pornography

REDACTED

SECTION C: PUBLISHABLE PAPER

**The critical inner voice and eating disorders:
An interpretative phenomenological analysis**

REDACTED